No. 288. Vol. IX.

PHILADELPHIA MEDICAL TIMES.

A BI-WEEKLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE.

EDITED BY HORATIO C. WOOD, M.D.

FEB 20 19

DECEMBER 7, 1878.

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TERMS.—Yearly Subscription, $4.00, in advance. Single Number, 20 Cents.

J. B. LIPPINCOTT & CO., Publishers,

715 and 717 Market St., Philadelphia.

LONDON: 16 SOUTHAMPTON ST., COVENT GARDEN.

Special Agents: E. R. PELTON, 25 Bond St., New York. A. WILLIAMS & CO., Boston. A. ROMAN & CO., San Francisco. BOSSANGE & CIE., Paris.

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PHILADELPHIA, DECEMBER 7, 1878.

ORIGINAL LECTURES.

TWO CLINICAL LECTURES ON PRIMARY INTRA-THORACIC CARCINOMA.

BY PROF. WILLIAM PEPPER, M.D.

Delivered at the Philadelphia Hospital, October 2, and October 9, 1878.

Reported by CHARLES A. OLIVER, M.D., late Resident Physician.

GENTLEMEN,—I shall now invite your attention to a very interesting case by reason of its obscurity. Although presenting well-marked symptoms, their explanation is rendered difficult by different possibilities. The patient is a blacksmith, aged 40 years, with the following history: perfectly healthy until within the period of the last two years, since when he has noticed that his voice has frequently been hoarse and husky, and occasionally there has been some difficulty in swallowing. About six months ago he had the symptoms of a slight pleuritic attack, recurring three months later. Œdema of the lower extremities for the past two months, accompanied by severe attacks of dyspnœa. Three weeks ago, the sharp respiratory pain in the left side was renewed, being constant and severe, attended with a slight cough and expectoration.

Present symptoms.—Emaciated; slight dysphagia; voice low, thick and husky. A great deal of dyspnœa, with accelerated respiration and rapid pulse.

Physical examination.—Inspection shows us that the left chest, in comparison with the right, appears fuller, the intercostal depressions not being so well marked; associated with an almost total absence of respiratory movement upon the same side.

Upon percussion, we find exaggeration of the right pulmonic resonance, with an absolute flatness upon the left side from clavicle to base, accompanied by marked feebleness of vocal fremitus and resonance.

Auscultation.—Upon the right side there is weak wheezing respiration with a prolongation of the expiratory murmur, and coarse sonorous râles. Upon the left side, below the third rib, there is an entire loss of respiratory murmur; above which level, anteriorly and posteriorly, can be heard distant blowing breathing.

Upon the 27th ult., chest-mensuration gave thirty-one and one-half inches as the entire circumference at the nipple-line, of which, upon the left side, from mid-sternum to the vertebral column, there were seventeen and one-quarter inches, the remaining fourteen and one-quarter inches being included in the same area upon the right side. A few days later a similar comparative mensuration showed a marked decrease, the entire circumference being thirty and one-half inches,—the right side fourteen inches, and the left side sixteen and one-half inches. In the chest tracing at the same level, we find the right side flattened and the left side almost semicircular; the respiratory expansion almost abolished. Cardiac examination shows great dislocation of the apex-beat, it being midway between the right nipple and the right sternal border.

What are the possible states to produce this group of symptoms? Only two; either a solid or a liquid formation in the left chest. Solid tumors of the pleura or of the lung do not give rise to such uniform dulness as in the present instance; again, solid tumors have a long period of incipiency, whereas here the symptoms quickly appeared; besides, solid growths will not give intercostal bulging, and here we have undue intercostal prominence. Consequently, everything indicates hydrothorax pushing the lung upwards and backwards, dislocating the heart, and arching the diaphragm inferiorly.

Upon referring to his history, we notice that he has had some dysphonia and dysphagia for the last two years, thus antedating the above symptoms. Upon inquiring into the cause, we find that laryngoscopic examination shows no vocal cord paralysis, œdema, exudation, or foreign growth, consequently excluding intra-laryngeal cause for the dysphonia. The dyspnœa, attended by the presence upon right side of feeble, wheezing respiratory murmur, with prolonged expiration and coarse sonorous râles, with but recent evidences of cough and expectoration, all indicate obstruction of the right bronchus. If we take the dysphonia and dysphagia in conjunction with the dyspnœa, they point to the presence of a mediastinal tumor, causing pressure on the trachea, œsophagus, and right bronchus; but would a so situated tumor produce pleural effusion? It

might do so by pressing upon the azygos and hemiazygos veins, thus preventing free return of blood from the pleural veins, with resultant hydrothorax.

Added to the above symptoms, we have one of great importance, though only to be detected by careful examination. By deeply pressing into the left supraclavicular space, we reach a mass of painless and movable glandular enlargements, some equalling the size of a hickory-nut.

We can also in cases such as this, where the cause of pleural effusion is obscure, secure aid in a diagnosis by an examination of the character of the effusion as shown by aspiration. If the liquid be turbid, highly albuminous, with a large proportion of coagulable fibrine, it is an evidence of its inflammatory origin; but if it is clear and limpid, and, upon standing, gives but a delicate veil of pseudo-fibrine, it indicates a passive or mechanical cause.

The œdema of the lower extremities we can attribute to anæmia, through absence of any organic cardiac trouble or abnormality in his urine.

We can exclude thoracic aneurism, by the patient having a good occupation, not being syphilitic, by the absence of a murmur synchronous with cardiac movement, by pupillary equality and mobility, and by no perceptible difference in radial or brachial pulsation.

Against the idea of tuberculosis with tracheal ulceration we have the absence of hectic fever, hæmoptysis, and cough, of physical signs of disease of the right lung, and of any morbid laryngoscopical appearances.

So we are forced to the diagnosis of some deep-seated thoracic tumor pressing upon the right primitive bronchus, œsophagus, trachea, and azygos and hemiazygos veins.

His treatment has been complete rest, milk diet, vesication over the seat of effusion, with the following prescription four times daily:

R Potass. iodid., gr. v;
Potass. acet., gr. x;
Tinct. digitalis, gtt. x;

and, if hydrothorax so increases as to cause sufficient dyspnœa to hazard his life, the advice of operative interference.

October 9.—Last night the patient died. If we could have prevailed upon him, we might have comparatively lengthened his life by performing paracentesis thoracis, relieving the pleural cavity of its enormous amount of dropsy, and thus taking pressure from the lungs, diaphragm, and heart.

[Dr. Pepper now, for explanatory purposes, aspirated the cadaver, obtaining a slightly turbid straw-colored liquid.]

Post-mortem examination, which was conducted before the class, showed the cardiac apex to be to the right of the sternum, in the fifth right interspace. There were several fluidounces of clear serum in the pericardial sac.

Left pleural cavity filled with a slightly turbid straw-colored serum, pressing the lung away from the costal pleura, with the exception of one strong pleuritic adherent band. The left lung was dense and compressed; its lower lobe was in a state of partial hepatization. The pleura pulmonalis was thickened and opaque, and presented several small nodules involving the outer layer of the lung.

The right lung was adherent to the chest-wall by strong pleuritic adhesions, its substance being congested and œdematous, but with no traces of tubercular deposition.

There was congestion and enlargement of the liver, with incipient cirrhotic change.

Anterior to the larynx, and pressing upon it, there was an aggregation of several enlarged glands, which upon section showed the appearance of encephaloid cancer with abundant creamy juice.

The glands both in the anterior and posterior mediastinum were involved, forming in front a mass of considerable size, which extended in front of the arch of the aorta and along the space between the left lung and the pericardial sac. Posteriorly, another elongated mass was found, imbedding both the descending aorta and the œsophagus. The glands around the right bronchus were much enlarged, so as to strongly compress the tube. The azygos and hemiazygos veins were imbedded in cancerous tissue, so that it was impossible to dissect them out.

Consequently, by taking the history and physical signs in concurrence with the autopsy, there can be no doubt that these enlargements are primary cancerous degeneration of the intrathoracic glands.

The development of the disease has been gradual; at first the glands becoming so large as to cause œsophageal and tracheal pressure. During the last few months the glandular enlargements compressed the azygos veins, causing pressure and me-

chanical pleural dropsy, with some slight subacute pleurisy. The existence of bronchial pressure became evident about the same time.

Microscopic examination confirmed the diagnosis of the cancerous nature of the glandular enlargements.

The case presents marked interest, not only on account of the obscurity of its diagnosis, but of the rarity of primary cancer of the intra-thoracic glands.

ORIGINAL COMMUNICATIONS.

DIFFUSE SPASM OF THE FACIAL MUSCLES—TRUE CONVULSIVE TIC—CASE IN A CHILD—RECOVERY.

BY V. P. GIBNEY, A.M., M.D.,

House-Surgeon to the Hospital for the Ruptured and Crippled, New York.

THE case I am about to report presents many points of interest, and, as my ideas of the pathology of the affection are very crude, I prefer to give all the details, thus leaving speculation for my readers. Some neurologists may object to the use of the terms in the caption, but, whatever may have been the lesion, I feel assured that mimetic facial spasm truly designates the disease, so far as symptomatology is concerned.

The cases I have seen reported occurred in adults; although I am free to confess that my search into the literature of the subject has not been such as I could have desired. Hypercineses exist in other localities, and, indeed, in this particular case a hypercinesis of one or more spinal nerves was a marked feature.

H. D., male, æt. 9 years, of German parentage, presented at the out-door department of the hospital, November 9, 1876. As he sat in the waiting-room, his grimaces were observed with much curiosity by the other patients. Every five or ten minutes, paroxysms would occur, the spasm beginning in the facial muscles and extending to those of back, a complete lordosis resulting. The attacks would last from twenty to thirty seconds, and then a period of perfect repose would follow. I sought carefully while making the examination for any exciting cause of the paroxysms, and could find none. On questioning the mother closely on this point, I gained no reliable information. They seemed to come on unpreceded or unaccompanied by any voluntary act. The spasm was notable in the corrugator supercilii and in the orbicularis of both mouth and eyes, was irregularly clonic in nature, and unattended by any pain.

The spasm, I had almost neglected to mention, affected likewise the muscles of the shoulders and hands during the paroxysm, the fingers being alternately flexed and extended in rapid succession. This, however, was not a constant sign, the face being frequently the only region involved.

He was well developed, and to every appearance in good health.

From the mother I learned that the boy had been thus affected about two years; that an attack of *rubeola* preceded the first motor signs by *about six weeks* or less; that prior to the rubeola he had ever enjoyed excellent health, and that even from this exanthem he seemed to make a good recovery; that the family history, both paternal and maternal, had been exceptionally good. So that I was utterly at a loss to find either predisposing or exciting cause without accepting the rubeola as such cause.

The progress of the case to date was that of apparent remissions and exacerbations without reference to periodicity. The beginning was not very decided, and it was the mother's impression that he had grown all along gradually worse. The paroxysms were altogether by day, and at night nothing had been observed. Whenever he contracted a cold (and this mostly affected the upper air-passages), the paroxysms were more frequent and the spasms more violent.

The fluid extract of ergot, in half-drachm doses three times a day, was ordered, and the patient sent to Dr. C. S. Bull for an ophthalmoscopic examination, which he kindly made, and wrote on November 15, "Boy emmetropic; vision normal; clear, healthy fundus; no hyperæmia." On this date I am informed by the mother that the paroxysms have been less severe and less frequent. The dose of ergot is ordered doubled.

22d.—Since last visit he has contracted "a cold," and the spasms are worse. Another feature which we at first failed to observe is now very marked, viz., a spasmodic flexion of left leg once or twice during the facial paroxysm. The mother says that frequently while he is walking this phenomenon is observed, even when no facial spasm is present. Some symptoms are now observed which strongly suggest intestinal worms, and three santonin powders, gr. iii each, are ordered, the ergot in the mean while to be discontinued.

29th.—Has passed a lumbricoid, since which there has been slight improvement. Santonin repeated.

December 2.—No further result from the administration of the vermifuge, though he sits in the office this morning for a full half-hour and no facial spasm occurs. The attacks are certainly less frequent. He still

"hitches up the leg" at times when walking. Ergot resumed, in drachm doses three times daily.

11th.—On more careful examination this morning, I find a moderate tenderness over cervical spine; a phimosis, *i.e.*, a long prepuce, with slight adhesions at corona glandis about two lines to right of frænum, which is itself short; glans is free from balanitis, and corona from smegma; no extra spasm is excited by handling the glans, and adhesions are easily broken up without hemorrhage.

18th.—Worse for past few days, in that the paroxysms are more frequent. Blister ordered to cervical spine.

29th.—No spinal tenderness, though condition of patient unimproved. Within past forty-eight hours the flexors of right leg have been observed in frequent clonic spasm. Ergot ℥i four times a day.

January 8, 1877.—The ergot has been rejected by the stomach; symptoms worse; during the early part of the week the spasm was in the flexors of the right leg; now it is in those of the left. One night recently he complained of severe pain in left thigh; has contracted a "fresh cold," and his grimaces have been more marked. Ergot discontinued, and Fowler's solution, gtt. v ter die, ordered, —the dose to be increased if stomach tolerates.

15th.—Has reached gtt. x, and the spasms are more severe, the paroxysms more frequent. The left arm and shoulder now participate in the movements. Dose to be increased.

19th.—Has reached gtt. xv ter in die, and puffiness of eyelids, with diarrhœa and gastric disturbance, indicates too clearly toxic effects: dose to be decreased to gtt. xii after a few days' cessation.

26th.—Takes gtt. xii without discomfort, but does not improve. The "hitching up" of the leg is the same, and there is now tenderness on deep pressure, and to warm sponges over spinous processes of seventh and eighth dorsal vertebræ. Blister ordered again, poultices to follow.

February 2.—Decided improvement; still taking gtt. xii of the Fowler.

9th.—Since last visit has suffered much constitutional disturbance; stomach very irritable; feverish; loss of appetite; loss of flesh, etc. Two days ago the medicine was discontinued, at which time the facial contortions were more marked than at date of last note. Pulse this morning 120; respiration normal; temperature 101°. Physical signs of chest negative. Ordered a mixture of chlorate of potassium, tincture of the chloride of iron, glycerin, and water; also brandy ℥ii twice a day.

14th.—Has been complaining for a few days of pain in right ear, and last night an otorrhœa was observed. Now the auditory canal is filled with a sanguineous crust. The "hitching up" of left leg is still prominent, and the facial paroxysms are more frequent, though not so severe. The tonic and stimulant to be continued, and the ear to be syringed out frequently with warm water.

23d.—No change, save in general health, which has improved. Discontinue the tonic and brandy; resume ergot, in *two*-drachm doses three times a day.

27th.—Decidedly worse. Spasm now imparted to flexors of thigh. Facial contortions hideous; no spinal tenderness. Discontinue ergot. Ether spray to spine this morning six minutes, with no immediate improvement. Spray to be continued daily.

March 1.—Has had three sprayings without any improvement; he fairly shakes the chair he sits upon. Santonin ordered, and spray to be discontinued for a few days.

5th.—Passed no worms, though there is notable improvement. Spine tender this morning. Ether ℥ii in spray to spine, without immediate benefit.

7th.—Very much better; no "hitching up" of either leg, and very little facial spasm, since last note. No spinal tenderness, though the spray is repeated this morning, the same quantity of ether used. As an appetizer, quin. sulph. gr. i ter in die is ordered.

17th.—Appetite good, and quinine discontinued.

20th.—There is steady though slow improvement. This morning a strong descending galvanic current to spine four minutes, instead of the ether spray.

28th.—The current has been applied every other day, with no appreciable benefit; spasms in statu quo. Ordered fluid ext. gelsemium gtt. v ter in die.

April 17.—The gelsemium has been well borne, and the dose has been increased so that he is now taking gtt. x. The paroxysms are very infrequent and very mild; spasm manifest only in the face.

27th.—Doing well; increase dose to gtt. xii.

May 7.—For past two days the convulsive tic of left face and left leg has been exaggerated, and there has been some epistaxis. Continue the gelsemium in same doses, and add the chlorate of potassium and iron mixture as above.

June 5.—On the 19th ult. the left ankle began to swell, and soon became very painful; next day the right ankle and both knees were involved; fever was marked, as also lumbar rachialgia: in fact, an acute articular rheumatism was fairly under way. At the end of a week, convalescence was apparent. This morning there is periarthritic effusion, with tenderness at left ankle and tenderness over mid-dorsal spine. No appetite; frequent epistaxis; facial tic marked. The case has been recently under the care of the family physician, and is to remain under his care for a week or two longer.

27th.—To-day he calls, and presents an exsanguinated appearance, is weak in the limbs, while the "hitching up" of one or the other

leg is still observed. The facial spasm is still the prominent sign. Now ordered the oxide of zinc, in pill, gr. ii three times a day.

July 3.—Since last note the dose has been increased, so that he is now taking gr. xii per diem, and with apparent benefit. Going into the country for two months, with directions to continue the medicine, and double the dose if relief be not prompt.

September 7.—Returned a few days ago, much improved in health, and facial tic not so marked as when he went away. Has taken no medicine for one month, owing to difficulty in getting prescription filled. Directions as to doubling dose not followed. The zinc is now ordered in gr. iv doses three times a day.

15th.—This dose nauseates, and half the quantity is ordered.

22d.—Even gr. ii nauseates, though "he has never been so still while sitting in school as he is now." Faint convulsive movements of the orbicularis oris are still observable, although the spasm of the leg-flexors has ceased entirely. Stop zinc, and take cod-liver oil ʒii ter in die.

October 6.—Since above date, has taken the oil with ease, and has gained flesh. The "facial tic," however, is still annoying. Ordered now the sulphate of zinc gr. ii, in pill, three times daily.

15th.—Violent clonic spasm of orbicularis oris and orbiculares palpebrarum coming on every two or three minutes, and lasting twenty seconds at least. This was observed by the mother last night *during his sleep*, though not so marked then as it is at present. Double the dose of zinc, and add half-ounce of Frommer's extract of malt three times daily.

April 20, 1878.—The above medicines were continued until the spasms were controlled, and then discontinued by the mother without medical advice. She calls now with the boy to report that no spasms have appeared for a long time. None can be detected this morning; he is in an excellent condition of health, attends school regularly, and is *cured*.

October 5.—At my request, he calls to-day. The mother states that he has had no relapse since her last visit, in April, though at times there is an involuntary frown. As he sits in the office, I observe an occasional movement of the corrugator supercilii; otherwise he is perfectly well, and this causes no trouble whatever. The mother makes the voluntary statement that "he has use for his handkerchief now," an article he had little use for during his malady. On following up this suggestion, I find that there was always an unnatural dryness of the Schneiderian membrane, and that since his recovery this has disappeared.

Remarks.—As to the etiology in this particular case, I have nothing definite to affirm. The sequelæ of measles are varied enough and surprising enough to include this affection, and it occurs to me that a plausible theory might be based on the fact that measles often leaves an otitis media as a sequel, or a naso-pharyngeal catarrh occasionally. The boy certainly had one or both of these affections. Now, peripheral irritation of the nerves distributed in these localities could act reflexly on the portio dura of the seventh pair, and thus cause this direct result of nerve-irritation. That no organic disease existed we are safe in concluding, I think, from the progress of the case. For the benefit of those who may regret that no laryngoscopic or rhinoscopic examination was made, I will say now that my friend Dr. Beverly Robinson kindly made the necessary examination for me during the month of November, 1876, shortly after the patient came under my observation, and he recognized only a slight degree of chronic thickening of the mucous membranes. It was he who suggested to me the probability of intestinal worms acting reflexly in a causative relation. He did not look upon the naso-pharyngeal lesion as of any importance. On his advice I ordered the santonin, and a lumbricoid was passed.

The examination of Dr. Bull eliminates any "error in refraction" from a causative relationship.

As to the pathology here I am free to confess my ignorance. Dr. Weir Mitchell has contributed largely to this subject in his many articles, and from his paper "On Functional Spasms" in the October number of the *American Journal of the Medical Sciences* for 1876 much information can be obtained. It is not uncommon for the spasm, which as a rule confines itself to the facial muscles, to attack muscles of the trunk or extremities during the paroxysm. Prof. Erb, in "Ziemssen's Cyclopædia," xi. 307, makes this observation: "In many instances an extension of the convulsion is observed to take place to adjoining muscular regions. . . . At the height of the attack the muscles of the neck and shoulders, and even of the arms, are often spasmodically affected."

The prognosis of this form of spasm is notoriously unfavorable, and proof sufficient can easily be furnished. Remak, however, states that in those cases that have become chronic a perfect cure is sometimes obtained.

My therapeutics may seem to some as too heroic; yet, when Erb says that "the

treatment of mimetic facial spasm is one of the most thankless problems of medical practice," I may be excused for zeal in pushing doses to their limit. The ergot, it will be seen by the report, seemed to promise good results, yet it ultimately proved useless. Arsenic, in the form of Fowler's solution, was given until toxic effects of a grave nature were produced, and not the slightest benefit was obtained. Had the disease been chorea, or even one of the phases of chorea, certainly some relief would have followed. The ether spray and the constant current were given fair trial, too, and yet these produced no marked results. The gelsemium was borne remarkably well, and the occurrence of an attack of acute articular rheumatism while he was taking gtt. xii three times a day may have been only coincidental, yet a causative relationship might suggest itself to some: still, in view of the well-known action of gelsemium on the peripheral nerves, one cannot see how such a relationship were possible,—*i. e.*, if we are at all disposed to regard rheumatism as of spinal origin.

A sojourn in the country did very little more than the medicines he had taken. It seems that the preparations of zinc, and especially the sulphate, accomplished more than anything else: still, the *vis medicatrix naturæ* may have, after all, brought about the end so happily reached. I have not reported the case to laud any special drug employed; I have simply reported it to show how even the most hopeless cases may sometimes terminate favorably, and how important it is to administer medicine with the view of reaching the physiological effects. The case furnishes good negative evidence concerning certain much-vaunted remedies. It illustrates, furthermore, how tolerant children are of certain poisonous drugs. I scarcely ever think of beginning on a child of ten years with less than five-drop doses of Fowler's solution, for instance. Much, indeed, could be said of this case, but already enough suggestions have been thrown out by certain facts connected therewith, and hence further discussion is unnecessary.

135 East Forty-Second Street, October 11, 1878.

The total number of patients treated in the out-door department of St. Thomas's Hospital in 1877 was 140,000. It is proposed to furnish to them, at cost, a lunch.

NOTES OF HOSPITAL PRACTICE.

JEFFERSON MEDICAL COLLEGE HOSPITAL.

SURGICAL CLINIC OF JOSEPH PANCOAST, M.D., EMERITUS PROFESSOR OF ANATOMY, J. M. C., FEBRUARY 9, 1878.

Reported for the *Philadelphia Medical Times*.

REMOVAL OF SUPERIOR MAXILLA FOR MALIGNANT DISEASE OF ANTRUM.

GENTLEMEN,—The first patient to come before us to-day is Oscar M., 39 years of age, who returns to show us the result of an operation for the removal of a large cancerous growth of the left superior maxilla. You will remember that the growth began in October, 1877, with swelling which he thought was due to cold. I performed the operation on the 9th of January, and the wound was entirely healed by the 16th of January. He was in a state of extreme emaciation and pallor; but he has greatly improved since the operation. Ether was given to the patient while sitting up in a chair. Forty-four minutes were required for the operation, in which the greater part of the superior maxilla was removed by external incision. I was able, however, to save most of the hard palate, and of course the soft, leaving the velum palati in its normal position. The external incisions followed the outline of the tumor. The first began immediately under the inner canthus of the right eye, and was carried almost vertically downward, parallel with the border of the nose, and through the upper lip, into the mouth. Another incision began rather external to the line of the external canthus over the zygoma, and ran downward, slightly curved outward, until level with the angle of the mouth, into which it was extended by a horizontal incision. This made a large flap, which was dissected from the growth. The tumor thus exposed was removed, with most of the superior maxilla, by the free use of the gouge, cutting through the bone with the strong forceps, removing also part of the malar bone and floor of the orbit and part of the hard palate. The disease apparently originated in the antrum, and was an encephaloid carcinoma. It grew downwards and outwards, which accounted for the ease with which it was removed. There was a little bleeding after the operation, so that, after securing all the vessels that could be found, it was necessary to

apply the hot iron. The wound was left open for a short time, and, when all oozing had ceased, the flap was brought down, and the edges of the wound approximated by several points of interrupted suture. It healed kindly, and was well in a week. The result is perfect, and we can now hope that the disease will not return.

NECROSIS OF HUMERUS—TIME OF OPERATION.

This young man shows sinuses around the elbow, evidently caused by necrosis of the humerus. As the dead bone has not yet separated, we will not attempt its removal. Never be in haste to remove necrosed bone with a chisel and mallet, as the operation will often have to be repeated. When the dead bone has separated from the living, forming a sequestrum, it is proper to liberate it by an operation, which is then likely to be successful.

FISTULA FOLLOWING PERINEAL ABSCESS.

This man, 42 years of age, presents a case of fistula in ano. Three weeks ago to-day I opened an abscess here, at the side of the bowel, and evacuated three gills of matter. Now he presents himself with a fistula, which admits a grooved director and enables me to divide the sinus and reduce it to an open wound. This will be packed by an oiled tent, and the wound will heal from the bottom by the granulating process.

GANGLION OF WRIST AND ITS TREATMENT.

This girl, 21 years old, shows us an enlargement on the posterior aspect of the wrist-joint. We call this a ganglion, I suppose, because it is not a ganglion at all. You know that the extensor tendons, running from the forearm to the fingers, pass behind the wrist-joint. Each tendon is surrounded by its proper sheath, in which there is always a little secretion to facilitate motion. In certain cases this secretion is greatly increased, probably from the result of irritation of some kind, and it forms a swelling whose contents are very much like calves'-foot jelly.

Never attempt to cut out such a tumor. It should be opened by subcutaneous incision, by passing a narrow straight knife through the skin at the distance of an inch or so away from the swelling, and then, passing it under the skin, open the cyst subcutaneously and press out the contents along this valvular incision. No air must be allowed to enter. The orifice can next be closed with a piece of sticking-plaster and a compress applied, in which may be included a small piece of sheet lead. We divide the sheath of the tendon forming the wall of the sac, before allowing the fluid to escape. The hand shall be put on a straight splint for a few days, to keep the parts at rest. As the bandage must be firmly applied, we must be careful to remove any rings that may be on the fingers, for fear of swelling. The roller is carried from the hand over the forearm as far as the elbow, and, since it is put on rather tightly, we must watch it, for fear of producing serious disturbance of circulation: even mortification may result. If there is any pain in the part, she may wet the bandage with cold water.

SPINAL ABSCESS, PATHOLOGY AND DIAGNOSIS.

The man entering the room presents for our inspection a number of sinuses on the right lateral portion of the back and the corresponding thigh and groin, evidently resulting from a lumbar abscess. This sometimes makes its appearance without being accompanied by much disease of the bone; but the original affection of the bone is generally tuberculous. When the disease is in the posterior part of the spinal column, low down, the pus from the carious vertebra, running downwards and backwards, dissecting and undermining the muscle in its course, is very likely to point in the lumbar region. On the anterior aspect of the spine the disease may be developed, and the pus following the psoas muscle may appear on the inner side of the thigh as a psoas abscess in the position of a femoral hernia.

I have no hesitation in making a diagnosis here of disease either of the two lower bones of the lumbar vertebræ or the upper part of the sacrum. When you have matter pointing in the neighborhood of the anterior superior spine of the ilium, always suspect iliac abscess. I recollect the case of a man who fell from a house: although he did not break any bones, he was badly contused. This was followed by inflammation of the sub-peritoneal areolar tissue, ultimately causing a fluctuating tumor in this region above Poupart's ligament. I laid it freely open, and obtained three pints of serous fluid after cutting through the abdominal muscles. He made a good recovery.

In a young lady coming from Cape

Island, there was a swelling in the left buttock. There was no history of injury, but it certainly contained pus and was an abscess. I did not lay this freely open, but evacuated it with the aspirator. From a certain knowledge which we get by experience, of the position of various abscesses, I was led to suspect a deeper origin for this. I inquired for a strumous history: it was denied, but I found scars, cicatrices, in the neck. I therefore diagnosed it to be a case of abscess originating in the abdomen or pelvis and working its way down out of the cavity through the groove for the gluteal vessels, just as an abscess in the head may discharge from the internal ear through the meatus. The cavity of the internal ear has running into it a continuation of the arachnoid from the brain. When this becomes inflamed, the abscess ulcerates through the foramen ovale and rotundum, and discharges externally, or it may even course along the nerves to the base of the brain. When there is disease of the ossicles, the discharge may flow through the Eustachian tube. The extension of the inflammation may involve the pneumogastric nerve in its course, producing great difficulty and interference with the innervation of the heart and lungs, or it may cause spasm of the larynx and danger of suffocation. It is always dangerous to allow the ear to run: chronic otorrhœa should not be neglected. I have seen meningitis set up by extension of the inflammation to the membranes of the brain along the course of the vessels. In one case the entire temporal lobe was rendered gangrenous from this cause.

Now, when there is disease in the spinal column in the vertebral bodies at the upper part, the discharge must get below the diaphragm; and it does this by going over the psoas muscle through the ligamentum arcuatum internum. It then gravitates downwards, still following this muscle as it goes towards the insertion into the femur, and points above Poupart's ligament or on the front of the thigh, or it may go backward to the loin, forming a lumbar abscess.

You remember the case of the boy who had disease of the dorsal vertebræ and had difficulty in breathing. I made this diagnosis, and told him that it would get better when the abscess worked its way through the diaphragm, either presenting in front as a psoas abscess, or, following the gluteal vessels, appearing in the back, as I before remarked.

All abscesses, however, in the lumbar region are not of this kind: they may originate in the fat and cellular tissue of this locality; and I have seen this following typhoid fever. In a case of ordinary iliac abscess from inflammation of cæcum and vermiform appendix, when the pus forms you should always let it out. You can very easily remove it with the aspirator; and I have even repeated this five or six times; but it is better to open it freely and encourage discharge. In the abscess of spinal disease the patient is liable to suffer from chills and hectic fever if the sac is laid freely open and the air allowed to enter. The pus must be discharged, however; and this may be done either by a valvular incision or by means of the aspirator.

INVERTED TOE-NAIL—PANCOAST'S OPERATION.

Ed. H., 20 years of age, has an inverted toe-nail of his big toe, on the right foot. We remedy this by shaving off the projecting skin until it is on a line with the lateral border of the nail. Performing this on each side, the nail is relieved, and a good cure will result.

CHANCRE AND PARIPHIMOSIS.

Geo. McD., 25 years, presents a characteristic condition of the penis. There is a comparatively large sore on the mucous membrane behind the glans, and retraction, with a dropsical condition of the prepuce, preventing it from being drawn forward. After cauterizing the surface with chloride of zinc solution, we endeavor to restore the prepuce by manipulation. Failing in this, we make a few punctures to drain off the serum, and make another attempt, which is successful. A wet dressing shall be applied, and he shall receive attention for the primary sore.

You should always relieve this condition of paraphimosis; otherwise it might lead to sloughing of the head of the penis.

PHILADELPHIA HOSPITAL.

SERVICE OF J. WILDS LINN, M.D.

Reported by CHAS. A. OLIVER, Resident Physician.

AMNIOTIC DROPSY WITH ADHERENT PLACENTA.

J. B., æt. 28, single, colored, born in Philadelphia; menses at twelve years of age; one child. Previous to pregnancy,

has had slight abdominal swelling, with œdematous extremities, relieved by diuretics and active purgation. Menstrual cessation about eight months ago. Has had morning sickness and gradual abdominal enlargement. Fœtal movements for last three months.

January 19.—Present symptoms.—abdomen very large, symmetrically distended from the symphysis pubis to the xyphoid cartilage; no facial puffiness; extremities not œdematous; on manual examination, usual signs of pregnancy. The urine is free from albumen and sugar, has an acid reaction, sp. gr. 1030, and contains uric acid and oxalate of lime crystals.

During January 20 she had false pains, and from noon of January 30 to the evening of February 1 she suffered from feeble pains at long intervals, the os uteri being but slightly dilated, merely admitting the tip of the index finger.

At 2 P.M of February 2, the pains still continuing, with but little increase of the dilatation of the os, it was decided to rupture the membranes and perform artificial dilatation.

Half an hour later, the membranes were punctured, allowing the escape of *over twelve pints of amniotic fluid*, and the os was dilated by means of a No. 2 Barnes' dilator. A binder was then applied, she expressing great comfort and sense of ease. Pulse 128, weak and thready. I ordered her a dessert-spoonful of whisky every hour, with tinctura digitalis, gtt. x, every second hour.

Examination at 7.30 P.M. showed the os fully dilated, the vaginal and uterine walls being almost continuous; vertex presentation, L. O. A. position; pains good, strong and regular.

At 8 P.M. she was delivered of a small female child. It gasped and breathed, but, finding cessation of cord-pulsation and a discontinuance of the child's respiration and heart's action, I cut the cord, and with great effort succeeded in full resuscitation.

At 8.30 P.M. I commenced the delivery of the placenta, practising both the common and Credé's method, but, finding no expulsion, ceased traction, and passed my hand and arm up through the vagina and external os, and found the placenta adherent, commencing at the internal os, nearly extending over the whole right side and fundus. Slowly peeling and dissecting it off, I extracted it, and, finding it complete, gave the woman a dessert-spoonful of vin. ergotæ; the third stage occupying one hour and forty minutes. Total duration of labor, over eighty-one hours.

At 11 P.M. the uterus was "well down," woman exceedingly feeble, pulse 116, weak and thready. Ordered the binder to be kept well tightened, and every two hours to have given—

℞ Ammon. carb., gr. x;
Tinct. digitalis, gtt. x;
Whisky, f℥ij.

February 3.—Child died. Mother doing nicely. Lochia natural in amount, color, and odor. She complains of after-pains. Uterus well contracted. Pulse fuller and stronger. Treatment of ammonia, digitalis, and whisky continued.

February 4.—Says "she is better." Abdomen becoming tympanitic, and temperature ranging high. Ordered hot turpentine stupes every other hour during the day, and quiniæ sulph. (gr. iij t. d.) Digitalis, ammonia, and whisky every four hours.

February 5.—Abdomen less tympanitic. Two turpentine stupes during the day. Quinine continued. Digitalis, ammonia, and whisky three times daily. Lochia becoming offensive, for which I ordered a disinfectant vaginal injection t. d. She had been vomiting, for which she was given the following pill:

℞ Creasoti, gtt. j;
Cerii oxalat., gr. ij.
M., et ft. in pil. no. 1.

Continued improvement until the 22d of the month, when she was seized with a violent attack of puerperal insanity, necessitating the use of straps to prevent homicidal intent, and the exhibition of anodynes to quiet her and cause sleep. Remained in that condition for several weeks, when it became necessary to transfer her to the Insane Department.

Seven years previously she had a similar transitory attack of insanity, occurring during her puerperal period.

936 North Fifth Street.

A paragraph in the *Dublin Medical Press* states that the London Cremation Society are fitting up a cremating apparatus—"Gerini's Cremator"—and in a short time it will be in working order. It will probably be fixed upon a plot of ground contiguous to Woking Convict Prison, Surrey.

TRANSLATIONS.

THERAPEUTIC USES OF IODOFORM.—From a recent review in the *Wien. Med. Presse* (1878, No. 36) of an admirable work on therapeutics, by Dr. Bernatzik, we take the following notice of the various uses of iodoform, culled from the current literature of the day. Internally, iodoform may be given in pill or pastille form, or in emulsion with white of egg, or in drops, dissolved in alcohol or ether, in the dose of gr. i ad iii. The pill form is preferable. It is said to be useful in syphilitic, scrofulous, and gouty troubles, in tuberculosis of the lungs, in carcinoma, chronic rheumatism, cardialgia, nervous headache, neuralgia, sciatica, and painful ulcerative diseases. Externally, iodoform is used as a powder for sprinkling on carcinomatous diseases and syphilitic sores; in the case of the latter by means of a camel's-hair brush, once a day only, the sore to be then covered with charpie and waxed paper or rubber. A similar application may be made to pointed condylomata, mucous patches, phagædenic sores, and ulcers of the cervix uteri; in the latter the iodoform may be strewn on rags wet with glycerin. Iodoform may also be applied with a brush or blown into the nostrils or pharynx in cases of syphilitic ulceration. Dissolved in ether 1 : 15, or in a mixture of alcohol and glycerin (2 to 3 parts of iodoform suspended in 30 parts of glycerin and 10 of alcohol), it may be used as an injection and as a local application—pledgets of lint or cotton being soaked with the mixture—to the above-mentioned sores. Dissolved in ether or alcohol (1 : 15–30), iodoform is recommended as a liniment in rheumatism, and as an application to rhagades, or fissures of the anus; also as an anodyne covering to abrasions of the skin in general. Suspended in water with the aid of albumen (albumen 1 : 50–100 aq.), it may be used as a gargle or enema. Dissolved in collodion, it may be applied as in the other solutions above mentioned. In the form of ointment (1 : 2–15 lard), iodoform may be employed by rubbing on scrofulous, cancerous, and other chronic glandular swellings, in scaly papular and tubercular skin-diseases, in hyperæsthesia of the skin, syphilitic headache, and as an application to fissures, syphilitic and painful ulcers, etc. Finally, in the form of plugs or rods, mixed with gum arabic, or in suppositories (iodoform., ol. amygd., āā 1, butyr. cacao 10–20), for the nasal passages, rectum, or vagina, iodoform may be employed in painful sores, particularly cancerous, of these parts or of the uterus. X.

MALIGNANT TUMORS IN INFANCY.—A number of interesting cases have been reported by Charon and Ledeganck in the *Bull. de l'Acad. Roy. de Méd. de Belgique*, 1878, t. xii. P. 5, p. 548 (*Cbl. f. Chir.*, No. 38, 1878). The first was one of medullary sarcoma of the right kidney in a child of five months. A tumor had been observed for some months in the right iliac fossa, rounded, movable, slightly tender on pressure, occasionally showing pseudo-fluctuation. Later the growth increased in size and became nodular. Urine normal. Death at eighteen months, from marasmus. Autopsy showed the tumor the size of a man's head, preserving the kidney form. The second case was that of carcinoma of the left kidney in a child of four years, the tumor being the size of a child's head, slightly movable, somewhat hard, with a nodulated surface, reaching downwards to the crural ring, upwards to the ninth rib, back to the vertebral column, forward to several finger-breadths beyond the navel. Puncture gave exit to bloody purulent fluid. The child had had fever and diarrhœa for two months. The subsequent history was unknown. The third case was one of carcinoma of the inferior maxilla in a child two years of age. The child died after four months, of marasmus. Autopsy showed the left kidney the size of two fists and containing a soft cancerous tumor. The fourth case was one of cancerous adenitis, of encephaloid character, developing in a child of five years. It first appeared in the knot of glands about the posterior tibial artery, but afterwards tumors were developed along the aorta, in the cervical region, etc. The child died within two months. This case is accompanied by pictures. A fifth case was one of congenital sarcoma of the face. The newly-born child showed an egg-sized tumor in the inner angle of the left eye. Bulb intact; the right half of the nose and the cheek were involved. In ten days the tumor, which was superficially fissured, spotted, yellow, and soft, reached the forehead and lips, and began to extend over the left side of the face. Death occurred on the twentieth day. Section showed miliary tubercles in enormous quantity in the subcutaneous

tissues, pleura, mediastinum, and pericardium. Brain normal. The large as well as the miliary tumors showed the structure of embryonal germinal tissue. (Plates are given.) The sixth case was one of villous degeneration of the bladder in a child three years of age. The boy had suffered with difficulty of urination for six months. The catheter struck some stony body (the encrusted papilloma). The bilateral incision was practised, and an enormous cauliflower excrescence was extracted. Two months later the growth was again quite large, extending from the wound. The child died three months after the operation. x.

Treatment of Prolapse of the Rectum in Infants.—Dr. Settimio Basevi (*Wien. Med. Presse*, 1878, p. 1153) speaks of the ordinary method of treating this accident, namely, by the application of a simple bandage after reduction, as being inconvenient and inefficient: it must be removed before each defecation. Basevi has suggested a new apparatus, which he has used successfully in a number of cases. In one, where the gut protruded four inches and had been out three or four days, it was reduced and cured; within twenty or thirty days the trouble was quite cured.

Basevi's operation is as follows. He cauterizes the mucous membrane of the intestine lightly with nitrate of silver, and replaces the gut. Subsequently enemata of tannin, alum, and ice-water are ordered, together with very strict diet, with a view to prevent enteritis. Should these measures fail and the intestine continue to come down, he uses his bandage as follows. The child is held by two nurses, with its buttocks up, over the bed, one securing the upper portion of the body, the other the slightly abducted knees somewhat up in the air. This position is most favorable for the reduction of the prolapsed rectum, because the child cannot bear down. After reposition the surgeon stands on the right side of the bed, with the thumb of the left hand pressing the child's left buttock to the right, while the fingers bring the right buttock towards and against it. With the right hand several strips of plaster of some two finger-breadths are drawn from below upwards and outwards, overlapping one another, across the buttocks, from one trochanter to the other. The strips should approach the perineum as closely as possible. As a support to the plaster, a spica bandage of two or three finger-breadths is run over the lower part of the body. A gutta-percha or waxed paper covering can be used to keep the buttocks clean during defecation, and this bandage can be retained in position for a couple of weeks. If diarrhœa be present, astringent enemata may be employed; if constipation, laxative enemata; and these should be given by the physician himself, for fear of disturbing the bandage. The latter can be changed without difficulty when necessary. x.

Artificial Nourishment of Infants.—Dr. Pletzer has recently published a small brochure on this subject, from which the following facts are extracted by the *Wien. Med. Presse* (p. 1165, 1878). Dr. P. believes condensed milk a very good substitute for cow's milk in the artificial feeding of infants, when the latter, the best of all substitutes for the mother's milk, cannot be obtained in purity. In order, however, to obtain cow's milk in the best possible condition for consumption in large cities, Dr. P. suggests the advantage of adopting, where practicable, "milk-institutes," such as are found in Stuttgart and Brunswick. Here the animals must be good milkers and of the best stock. Their food is to be selected carefully by competent persons, and the hygiene of the stall and of the individual animal is to be carefully looked after. Cleanliness in the minutest particulars with regard to the milk-room, the vessels, etc., must be exercised. Medical examination of the cattle should be practised frequently. If such measures were taken to insure the purity of the milk-supply, a very valuable substitute for mother's milk would be found in this *pure* cow's milk. x.

Action of Tincture of Iodine on the Neck of the Uterus.—M. Laboulbène (*Bull. de Thérap.*, August 30, 1878) says that tincture of iodine colors the healthy cervix a uniform dark brown. If slight ulceration exists, the patch is colored yellow, showing distinctly against the surrounding color. All granulations and vegetations are colored yellow. After the application of the actual cautery, which M. Laboulbène recommends in ulceration of the cervix, iodine gives the yellow tint until the cure is completed, and then gives the brown color. If the neck of the uterus is large, and the tincture of iodine produces islands of yellow color, a neoplasm may be apprehended with approaching ulceration in the points least colored. The diagnostic value of the iodine may easily be perceived. x.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, DECEMBER 7, 1878.

EDITORIAL.

NATIONAL HEALTH ASSOCIATION.

THE late meeting of the National Health Association appears to have been the most successful and important ever held. The horrible waste of life, the terror and the loss of the late yellow fever epidemic have created, for the time being, a national popular interest in hygiene never before felt, and the national interest reacted most favorably upon the devoted band of physicians and laymen who for years have been spending labor and substance in endeavoring to save the people from their filth.

Of course yellow fever claimed the precedence. The excellent report of the Commission appointed by Dr. Woodworth, and the preparation of the subject for discussion by the preliminary committee of the Association, gave point and intensity to the proceedings which might have otherwise been lacking. The most important facts developed by the report of the Commission were, that the fever in the recent epidemic nowhere arose *de novo*, but was carried in clothing, goods, bedding, by persons, &c.; that disinfectants failed utterly, often doing harm rather than good; that personal prophylaxis proved a constant failure, although some physicians were found who thought the use of small doses of quinine of some preventive value; and that absolute quarantine had, without exception, afforded complete protection.

After the reading of the report, views most various were freely discussed. The belief in the contagiousness of yellow fever seems to have gained ground decidedly among those who witnessed the recent epidemic, although this contagiousness is usually thought, by those who hold to it most strenuously, to be peculiar and its effects only witnessed under certain circumstances. The final sense of the assembly was expressed in the following series of resolutions, based upon some offered by Dr. Billings:

1. The yellow fever of 1878 was a specific disease, not indigenous to or originating during that year spontaneously in the United States, and its appearance in this country was due to a specific cause.

2. Quarantine established with such rigor and precision as to produce absolute non-intercourse will prevent the importation of the specific cause of yellow fever.

3. It is the duty of the general government to aid in the establishment of a practical and proper quarantine by all means in its power.

4. It is the duty of the general government to appoint a commission of experts to make a thorough investigation into the causes of yellow fever and the best methods of preventing its introduction into this country, and to make such an appropriation as will permit of securing the services of the best men and of the best means for carrying out such investigation.

5. It is the duty of the general government to invite foreign nations to co-operate with it in the establishment of uniform and effective international quarantine regulations.

6. Whatever may be the practical value of quarantine, there is no doubt of the importance and value of internal sanitary measures in the prevention or modification of epidemic yellow fever; and this Association strongly urges upon State and municipal authorities the great amount of responsibility which rests upon them on this account at times when no disease is prevalent or threatening.

A resolution of heartfelt thanks was awarded by acclamation to Mrs. Thompson for the funds contributed by her to the Yellow Fever Commission. This was right; but in doing this the Association should have given official expression to the disgrace of the nation's accepting or requiring such a gift. That a people blessed with unbounded wealth—gifted in other matters with an unequalled shrewdness—should leave the prevention of such

calamities as the recent epidemic to the chance charity of the hour, seems as inexplicable in its fatuity as it is sorrowful in its reality.

Our government sends its astronomers across a continent to view an eclipse, its "bug-hunters" into every crevice to find a new beetle or parade a new spider, whilst it withholds what is, in all verity, the bread of life from dying multitudes. Now, if ever, is the iron hot and the time to strike come. Now is an awakened nation saying, "What shall we do to be saved?" and to every hygienist comes the pressing duty to labor for governmental aid and recognition with the authorities.

The Association did, in urging the creation of State boards of health, do one act for which it deserves praise; but why it did not go further and urge upon Congress by committee, and in all other possible ways, the creation of a department of hygiene, we do not know. In not doing this to the full extent of its power, according to our thinking, it has failed to do the one thing most needed.

In another column we print an account of a visit to the President by certain memorialists. Comment is scarcely necessary, but we would call attention to the fact that the major includes the minor, and that the proper thing to be done is the creation of a national health department, which should have charge of all the national problems of preventive medicine.

CORRESPONDENCE.

LONDON LETTER.

COUGHS are getting common at this season, and need some consideration. It is with evident surprise that patients receive the announcement that they do not know how to cough. Clearly, people regard the act of coughing as a subject not requiring any ratiocination, not likely to be benefited by education. But in that they are greatly mistaken. Certain it is that there are some persons who are too stupid to be taught how to cough properly; but the bulk of patients are grateful for the information. Some unfortunate individuals with chronic bronchitis and emphysema are physically incapable of coughing efficiently. Their barrel-shaped chests with ossified costal cartilages do not admit of that full expansion of the lungs which ought to precede the act of coughing. For them there is nothing but pity; but for the mass of people who cough, one's pity is limited. It is perfectly true that the act of coughing is a reflex act, but still it can be influenced by the will, guided and directed, and, if Victor Hugo is to be trusted, even absolutely restrained by a French prisoner attempting to escape from prison. Under less trying circumstances the cough is indulged in. In that form of cough which results from a dry, irritable mucous membrane, where the cough is persisting and goes off in paroxysms, little control can be exercised over it by the will. On the other hand, with the form of cough which usually occurs in the morning on getting out of bed, the very opposite is the case. This form of cough is one very frequently complained of by patients, and it is worth consideration. First, its causal associations must be reviewed. There is a little more formation of mucus on the bronchial lining membrane than in warmer weather. Smuts of infinitesimal size, molecules of soot, and other minute matters are inhaled, and are caught on the moist mucous surface, as seen in the dark-gray masses expectorated. A visit to a manufacturing district is usually followed by the expectoration of such masses for several days after leaving the neighborhood. These masses gather during the day, when there is ordinarily little or no cough, and also during the night. The different points on which these masses accumulate gradually become tolerant of them, and the reflex act of cough to remove them is not set up. On leaving the recumbent posture, and getting up, these masses slide from their place on to other parts of the mucous membrane which are not tolerant of their presence, and then follows cough for their removal. This is the simplest form of cough; there is an irritant in the air-passages, and cough is set up to remove it. It commonly happens that the time this irritation is most felt is at or near the end of expiration, when the sides of the air-passages are approximated. It is not very comfortable to cough with the chest emptied of air, or comparatively so, and cough then is very ineffective. Cough, then, is protracted until the face is congested and a feeling of suffocation experienced. The sufferer may be rendered temporarily blind, or almost unconscious, till at last the blood becomes so highly venous that the respiratory centre is stimulated to a tremendous explosion; a powerful inspiratory effort is the result; a quantity of air is sucked in behind the offending mass; the expiratory cough expels it, and relief is obtained. Some people resist

with all their power this strong inspiratory act, and consequently the expiration is not successful in removing the source of irritation. Then follow, at a brief interval, another series of imperfect attempts to cough with an empty chest, with the same result: the powerful inspiratory effort being resisted or arrested by the reflex impulse to cough, the mass remains unmoved, or is but partially removed. These efforts dislodge other masses from their locations, and then several centres of irritation are established, with the result of a prolonged series of coughing-fits. When the individual has a small chest which does not expand readily, this spell of coughing is protracted, and may last intermittingly half an hour or more, the act of dressing being much interfered with. This, of course, is very disagreeable in itself, and in elderly persons is very injurious to their lung-tissues. Young people may cough a good deal and take a good many liberties with their lungs with impunity, but this is not the case with older persons, whose lung-tissues are not so perfectly nourished, and every attack of cough produces so much more vesicular emphysema, the lung-tissue being torn by the strain put on it. Such being the facts of the case, it becomes very desirable that persons who have to cough should be taught how to do it efficiently, just as we instruct people how to gargle their throats, when that troublesome operation is necessary. It must be insisted upon that the chest be well filled with air before the cough is let loose. That is, the reflex act must be inhibited by the exercise of the will until the chest be filled with air, and then the offending mass will be quickly dislodged. Such full inspiration is effective not only in removing the source of irritation, but it usually causes other masses of mucus and charcoal to slide from their seat, and thus to set up further cough for their removal. But if the "full inspiration cough" plan be followed, these masses are readily and quickly got rid of. *Experte credo!*

Of course it is much easier to execute this manœuvre where there is a large chest, which is readily and easily expanded, than with a small, narrow chest, and also where the lungs are not torn up with emphysema. Still, all patients ought to be taught to cough on correct physiological grounds. I give many a lesson on coughing to my patients at Victoria Park Chest Hospital, many of whom exhibit an air of incredulity blended with amusement,—and come back next week with profuse and grateful thanks for the instruction and the comfort which has resulted therefrom. A Cockney is usually an individual with acute perceptive faculties, and has a true Anglo-Saxon willingness to learn, especially when he or she sees something to their individual advantage to be secured. To the credit of the Cockneys, too, it must be said that their emotions are generally very creditable, and they are not too shy or too reticent to give their thanks very genially when they have got good from anything; and the expressions of gratitude tendered for a lesson in coughing are often touching and gratifying. When the patient is an elderly person, with labored respiration, panting for breath,—with a dusky complexion, a tortuous temporal artery very conspicuous on each side,—with rotten lungs, a dilated right heart, a trace of albumen in his water, more than a suspicion of chronic kidney disease, and fatty-like casts, if one had time to hunt for them,—a general state of ripeness merging into rottenness,—every act of cough is painful and destructive. It is followed by further injury to the decaying lung-tissue, and so is to be obviated by every possible means,—except the administration of opium or its derivatives. Sedatives are admissible where there is an irritated mucous membrane and a dry cough, or where a mass of tubercle sets up reflex cough, acting like the thorn of Van Helmont, and, as yet unsoftened, its removal by cough is physically impossible. But they are far from an unalloyed good, and should never be given if it is possible to avoid doing so. In the form of cough just described they are distinctly contra-indicated. They cause the secretions to be more viscid, and therefore more difficult of removal: they ruin the appetite and disturb the bowels. Paregoric has done as much harm as good in its history, and cough-mixtures are too frequently mischievous abominations. Cough-lozenges are not innocuous if efficient. "What, then, should be done?" some irritated reader may inquire. To this I must answer that at least the patient must not be made worse. In the morning cough just described, a little sal volatile with spirits of chloroform in peppermint-water makes a much better mixture than the morphia-poisoned chalice too commonly prescribed. The art of medicine frequently places the practitioner in the predicament of substituting a lesser evil for a greater one. But a cough-mixture containing quantities of opium is too often not a lesser evil than the cough. When a poor wretch whose lungs are riddled with tubercle—softening masses alternating with cavities whose contents have recently been expectorated—is on the down-hill road to the grave, and nothing short of a miracle can arrest the progress, then the administration of opium is permissible enough: its use is part of the euthanasia. But as long as the patient has got fight in him, or her, sedatives should be studiously eschewed. If the grave has an insidious, cunningly-devised path to it, it is the one which is strewn with opium. The immediate comfort afforded by the subtle poison gives it its weightiest attraction, and the greater the relief experienced from it the more it is to be shunned,—at least during the day.

To bring sleep at night the use of morphia or opium is less objectionable; though even

the drawbacks to their use there are conspicuous enough. Sleep is essential, and must be procured at all hazards, and for this purpose, in the cough of advanced phthisis, large doses are unavoidable. But then atropia must be combined therewith to stave off the depressant effects upon the respiratory centre, and to check the activity of the sudariparous glands, both undesirable actions of opium, which must be antagonized; and the vehicle must be pil. aloe et myrrh, which keeps the gastro-intestinal canal in good order. But for cough which is the result of bronchial secretion, opium is an unmitigated evil. It paralyzes the efforts which are requisite for the removal of the source of irritation. Of course, where people have got a cold, but are not seriously ill, they may tinker away at themselves with paregoric or any other mild opiate, pleasing themselves and doing little harm; but when serious and grave illness has to be encountered, the matter is very different. I have known an ordinary hospital pill, of a quarter of a grain of morphia, put a poor fellow at rest forever. He had had several sleepless nights, and one pill "slept him beautiful," as his wife phrased it. At seven in the morning she could not rouse him; nor were her apprehensions aroused either, for, she continued, "he passed away so quietly at eleven." A great many other people pass away very quietly too, only not quite so quickly, from the use, or rather abuse, of opiate cough-medicines. If there be much useless cough in any case, *i.e.*, cough that is ineffective and unaccompanied by the raising of phlegm, then some agent which acts on the nerve-tracts over which go the afferent sensations to, and the efferent motor messages from, the respiratory centre, is clearly indicated. Bromide of potassium may often be substituted for morphia with advantage, and is fairly effective; it has, moreover, fewer evil after-consequences than opium. Hydrobromic acid, with spirit of chloroform and syrup of squill,—and, if the case be that of a very agreeable lady and a favorite patient, a few drops of spirit of nutmeg may be added,—constitute an excellent and palatable cough-medicine. Patients not only take this mixture readily, but coughs become quite in vogue in the household as long as any of this delectable compound is on the premises. Paregoric in camphor mixture or peppermint-water is not to be compared to it.

When the necessity for a full dose of morphia is imperative and must be acknowledged, then it is well to give with it atropia, in order to antagonize the depressant effects of opium upon the centres which preside over the circulation and the respiration.

Had the pill which killed the unfortunate patient alluded to above contained some atropine, the disastrous consequences might have been averted, and the patient's life prolonged. The unconsciousness which resisted the efforts of his wife to rouse him would have awakened suspicion and anxiety in a less ignorant woman; but in her unsuspecting ignorance she allowed her husband to remain unroused until the sedative effects of the opiate gradually paralyzed the respiratory and circulatory systems, and death followed. Unconsciousness is not the danger itself, but it is the danger-signal, which should warn us that the essentially vital centres must be influenced by the narcotic very shortly, and the case should be attended to without delay. The subcutaneous administration of atropia, or, probably even better still, strychnia, would be indicated, and would in all probability be successful. This brings me to an important matter, viz., the very strong probability of a distinct antagonism existing between strychnia and opium upon the rhythmically discharging centres; and I can conceive no more interesting experiment than to test this thoroughly. The fetters of the Vivisection Act have prevented my doing this; but the probabilities are such that it is very desirable that some person in your unhampered land should pursue such investigation and report the results. It would be easily done. The lethal dose per pound of strychnia for the rabbit is well known, and it would be very easy to find out the lethal dose of opium and morphia. If a distinct antagonism be found, a good work would be done, and the dangers of opium-poisoning be greatly lessened.

But this is a digression; and the subject of cough, and especially what may fairly be termed winter cough, is not yet exhausted. There are the means of prevention to be considered. The mucous rheum which calls out the morning cough is due to the changes of temperature to which the lining membrane of the air-passages is exposed in cold weather. People pass rapidly from in-door temperatures of 60° Fahr. to out-door temperatures varying from 40° to 32°, and far below that very often, and then changes in the vascular supply of the mucous membrane of the air-passages are set up. If everybody at all times only breathed through the nose, the inspired air would be warmed by passing over the coils of blood-heated plates which exist in the nose for that purpose, and would not affect the air-passages placed behind the turbinated bones. But such is not the case; they probably commence to talk, and in doing so draw in by the mouth cold air, which, on mixing with the residual air in the chest, lowers its temperature, and then a fluxionary hyperæmia follows, and after it, in its train, a mucous rheum. The best plan for persons who thus catch their winter cough to adopt is to keep their mouths closed; but then humanity is not generally prepared for such self-denial, and the respirator suggests itself as the agent required. A respirator is not an ornamental thing, and its appearance is not in its favor. Its use

subjects you to the remarks of inconsiderate and unreflecting friends and acquaintances, who point significantly to the unsightly contrivance, and express their regret that you should be compelled to wear such a thing; and the insurance agent, when you call to pay the premium on your policy, looks excited and nervous. Having worn a respirator for eight winters now, and knowing how little I have been troubled with bronchitis since, which previous to then for some years had made winter a very uncomfortable season, I am very little perturbed by such incidents, and reply that "I don't wear a respirator because I am ill, but because I don't wish to be ill." And a wonderfully comfortable thing it is! It keeps the cold wind from blowing into the mouth when facing it; and surely it is as natural to cover the orifice of the mouth in winter as it is to shut the front door to prevent a cold draught pervading the house. Ladies who take carriage-drives wrapped in furs copiously and provided with foot-warmers in their carriages and flasks of hot water in their muffs often catch cold when out. If they would further conserve and economize their body heat by the use of respirators, which take up some of the heat of the warm expired air and give it off again to the cold inspired air, then they would not only be more comfortable, but they would escape many a catarrh and much coughing. Whether it is consistent with the interests of the profession thus to instruct the public how to keep themselves well, or not, may not be affirmed. The respirator in some form has a great future before it.

Then again there is still left the subject of underclothing in winter. Many poor people can't get proper underclothing; but plenty of persons who can purchase proper materials do not do so. Especially is this true of women, numbers of whom have only a cotton chemise under their corset even in the coldest weather. The severe winters of your continent may have taught women to dress more judiciously, but here in too many instances the grossest carelessness is found. It is scarcely possible to write dispassionately about female underclothing, or rather the want of it. I often study the shop-windows where female underclothing is sold,—as a bachelor I have no occasion to make their further acquaintance,—and contrast them with gentlemen's hosiers, whose windows are crammed with merino vests and drawers, flannel shirts, etc., the female shop-windows being hung with linen and cotton vestments. Why, in the name of common sense, don't women wear a woollen outer skin in winter as well as men? Above the corset, as experience at a chest hospital amply demonstrates, there is frequently only a frilled chemise under the gown,—not one single scrap of flannel, very often. The chest-walls of women are not generally very thick over the subclavicular region, and the low external temperature must affect the apices of the lungs and cause vascular disturbances in them, resulting often in disease. It is all very well for women to wear fur jackets, *i.e.*, for those who can afford them to dress so, but the majority have to go without and wear thick cloth jackets instead. But no amount of external garments will compensate perfectly for the lack of sufficient and efficient underclothing. The very weight of these heavy jackets is burdensome to women of feeble frame, and compels them to walk slowly and languidly, so that they can scarcely maintain their body heat, and get chilled: whereas if they were clad in woollen undergarments they would not require the heavy jackets they wear, and lighter raiment would enable them to walk more energetically and thus raise body heat, while the woollen outer skin would efficiently conserve it. The high temperatures in-doors which women like are not only enervating, but they render them very susceptible to cold out-door temperatures, and, by increasing the difference betwixt the two, artificially cultivate a susceptibility to catarrh. The subject threatens to be boundless: so, with a due regard for your space, I will conclude by saying, if women wore more appropriate underclothing in winter they would not require such high in-door temperatures, and so would escape many a cough, cold, or catarrh for which their present mode of clothing is largely responsible.

J. Milner Fothergill.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

Thursday Evening, September 26, 1878.

The President, Dr. H. Lenox Hodge, in the chair.

Pathology of urethral stricture. By Dr. John H. Brinton.

Dr. JOHN H. BRINTON exhibited to the Society a series of specimens illustrative of stricture of the urethra. These specimens, Dr. Brinton stated, had been taken from patients who had died at various times during the last eight years at the Philadelphia Hospital, and were in the highest degree instructive, showing, as they did, how fatal consequences under certain circumstances may follow operations usually regarded as comparatively free from danger. In presenting the preparations for the study of the members, Dr. Brinton remarked that it must be borne in mind that the operations in the several cases were performed upon patients in the lowest social scale. These were, in fact, paupers, confessing to intemperate habits, and whose lives, as far as known, were of the most irregular and exposed character. In every case operative in-

terference of some sort was unavoidable, of necessity and not of mere election, and the special operation performed was chosen with the view of giving each patient his best chance of recovery and life. These facts must be recollected, so that neither operator nor operation may be unfairly credited with results which should properly be charged to the patient's disease, his broken constitution and depraved circumstances of life.

The first of these specimens is a urethra and bladder, with the following history.

W. G., æt. 37, of intemperate habits, was admitted into the Philadelphia Hospital in 1870, suffering from a stricture the result of a gonorrhœa contracted four years previously. The stricture was annular in character, one-quarter of an inch long, and distant from the meatus two and three-quarter inches. He had for two years experienced great difficulty in micturition, and frequently introduced a flexible catheter himself. After drinking, the stricture was usually very tight. When first seen, he could not urinate, and the introduction of the catheter produced much irritation. The stricture was first divided carefully by Charrière's urethrotome from behind forward, and then slightly dilated by a Holt's dilator, and Thompson's sound No. 16 of the French scale carried into the bladder. The urine was subsequently drawn off by a No. 8 English flexible catheter. Three days after the operation, suppression of urine occurred, followed by death two days later,—that is, five days after the operation.

Post-mortem examination exhibited both kidneys large and congested, ureters normal, bladder holding six ounces of high-colored urine, vesical mucous membrane slightly congested but not softened. A urethral stricture, two and three-quarter inches from meatus, was well divided. There was no extravasation or urinary infiltration below the mucous membrane. An old false passage extended from one inch in front to two inches behind stricture, admitting a No. 10 English sound. There was great congestion of prostatic sinus, and beneath this, on the left side, a cavity half the size of an almond, filled with pus. The prostatic plexus of veins was dilated, inflamed, and gorged with blood. It will be noticed that here the brunt of the destructive action had fallen upon the prostate gland and plexus of veins, and upon the kidneys.

Preparation No. 2 was taken from a negro, W. D., æt. 35, who was admitted into the hospital June 13, 1872. He had at that time two strictures, both firm and annular, and situated respectively one inch and two and a half inches from the meatus. A whalebone filiform could with difficulty be carried through the strictures. Urination was attended with much straining and difficulty. Some irritation followed the introduction of the filiform bougies. On June 26, internal urethrotomy was performed with Charrière's urethrotome, and Thompson's sound No. 18 was carried into the bladder. In three or four days the patient could introduce No. 18 or 20 flexible catheter himself. He passed his water readily, and was apparently in good condition. On the 20th of July he lay down in the wet grass to sleep; nephritis ensued, and he died July 26, thirty days after the operation. The *autopsy* revealed multiple abscesses in both kidneys, with dilatation of ureters and pelves. The bladder was thickened and contracted, with a capacity of scarcely two ounces. The incisions through the strictures were completely healed, and the calibre of the urethra was well established.

In the third preparation upon the table we have a stricture the result of a gonorrhœa contracted seventeen years before, developed in an intemperate man, J. W., 45 years of age. He was admitted into the Philadelphia Hospital on the 13th of December, 1873. He stated that the symptoms of the stricture first appeared after a march, while in the army, in 1864, and that since that time he had been troubled every six months or so with retention of urine, usually brought on by drinking. He had retention when admitted, which was relieved by catheterization with flexible instruments of small calibre. Metallic instruments up to No. 15 or 16 French were subsequently introduced, but he gradually became weaker and more emaciated, and died on January 20, 1874. During the treatment he voided pus from his bladder in large quantities, and he occasionally suffered from retention. He was subjected to no operative interference except the gentle catheterism above referred to. At the *post-mortem* examination the walls of the bladder were found to be thickened and suppurating, and its cavity contained two and a half or three ounces of pus. In front of and surrounding the anterior portion of the prostate was an abscess the size of a walnut. On opening the urethra, a stricture an inch long was found, one and a half inches in front of the membranous urethra, and beneath the structure a false passage running backward in the direction of the triangular ligament. This false passage communicated with the urethra by three small openings before it connected with the membranous urethra through its main opening. At the time of his death the patient was greatly emaciated, weighing little over one hundred pounds.

The fourth specimen exhibited by Dr. Brinton consisted of a bladder, urethra, testicles, and kidneys, taken from a German, L. S., æt. 41, admitted to the Philadelphia Hospital, February, 1875. When received into the hospital the man was in a very terrible condition, and stated that he had decreased in weight more than fifty pounds during the last month. He was suffering from a urinary abscess of large size, the perineum, scrotum, and adjoining structures being greatly distended. The abscess, which burrowed in every direction,

had ruptured by the side of the anus, and through this adventitious opening all of his urine passed, none coming by the meatus. The man was weak and feeble, with a quick pulse. The insertion of a sound revealed a firm stricture a little more than two inches from the meatus. With some difficulty a filiform whalebone was carried through the stricture, and over it a small catheter, through which a small quantity of urine was drawn off. The patient's condition was so urgent that it was determined to make an immediate attempt to open up the urethra and to check the burrowing and extension of the abscess. A free incision was accordingly made in the abscess, and a large quantity of urine and pus evacuated. The finger, carried through the wound, passed into a large abscess surrounding the prostate and extending up on the right side of the bladder. The apex of the abscess could not be reached by the aid of the finger. A filiform whalebone was passed through the stricture, which was readily burst by Voillemier's dilator; Thompson's sound No. 25 was then readily introduced into the bladder. A large-sized flexible catheter was inserted into the bladder, and left *in situ*. The patient gradually became weaker and weaker, symptoms of uræmic poisoning appeared, and he died five days after the operation.

The following were the *post-mortem* appearances: kidneys enlarged and congested, ureters healthy, bladder contracted and walls thickened; tubercular deposits in both lungs, and also similar deposits studded over the surface of the bladder. A large urinary abscess reached nearly to the top of the bladder, involving the front of the prostate gland, and communicating by two openings with the membranous urethra. There was a large tubercular abscess in the right testicle. The effect of the divulsing instrument had been to fairly slit up the stricture and the mucous membrane for an inch and a quarter as sharply and cleanly as if they had been cut by a knife. There was no infiltration external to the mucous membrane.

5th specimen.—In January, 1877, D. S., æt. 45, was admitted into hospital suffering from two strictures, the result of two attacks of gonorrhœa, which had been contracted, one ten years and one one year previously. He had great difficulty in urination, and at times suffered from complete retention. At first only the smallest catheter could be passed; but the size was gradually increased, so that in twelve or fifteen days an English No. 8 could be introduced. The strictures, which were situated, one two and a half inches and one five and a half inches from the meatus, were then gently stretched by Holt's dilator, but not divulsed. This proceeding was followed by a high degree of urethral fever, and by persistent hiccough, and the patient died eleven days after the operation. The urine was carefully examined before the operation, but not a trace of albumen could be detected.

At a *post-mortem* examination, the kidneys were found to be greatly enlarged, each one displacing more than one hundred and fifty ounces of water. Each kidney was filled with multilocular cysts containing a limpid fluid. Both lungs were œdematous, but not pneumonic. Heart normal. Liver normal, but pressed up against the diaphragm. The urethra appeared healthy; the stricturing points could be readily made out, but admitted No. 10 instruments. The mucous membrane was not torn, split, or congested.

The last specimen exhibited by Dr. Brinton presented the following history. C. L., a man aged 66, of intemperate habits, was admitted into the Philadelphia Hospital in the early part of 1878. He had had a gonorrhœa when young, and twenty years since, having difficulty in passing his water, he went to a dispensary, where the meatus was cut by a bistoury, and bougies passed. The meatus afterwards recontracted, and from time to time he has himself passed small flexible bougies and catheters. At times the opening of the meatus was, he said, very small indeed, and gave him much trouble in urination, and some pain when he attempted to dilate it. On the 9th of February, about two o'clock in the afternoon, Dr. Brinton, at the patient's earnest request, divided, with a Charrière's urethrotome, the stricture, which was very firm and dense, and situated about three-eighths of an inch from the meatus. The patient experienced no pain during the momentary operation. A little quinine and opium were ordered him, and he was directed to remain in his bed until the morrow. At 7 P.M. he passed his water, and was quite comfortable. At 11 P.M. he had a chill, which lasted fifteen or twenty minutes, but was relieved by hot coffee and external warmth. Five grains of quinine were then given him; he slept comfortably from twelve until three, and from three till six in the morning; at this time he awoke, talked with the nurse without experiencing any chill, discomfort, or unusual feeling, and five minutes afterwards turned over in his bed and died.

The *post-mortem* examination was made under the direction of Dr. Shakespeare, the pathologist of the hospital, but the most careful scrutiny failed to detect in any organ the cause of death.

After the specimens above described had been examined by the Society, Dr. Brinton briefly directed the attention of the members to the manifold causes of death in the respective cases,—to wit, inflammation of the prostatic plexus of veins, inflammation of the prostate gland, and prostatic abscess, acute nephritis, pyelitis, multiple abscess of the kidney, cystic degeneration of the kidney, extra-prostatic abscess, and tubercular deposits in the bladder and testicle. He remarked that while in most cases the autopsy sufficiently

accounted for the fatal result, in the case last recorded absolutely nothing was developed which threw any light on the cause of the death. The man was operated upon, and in eighteen hours died; whether in consequence of the operation or simply as a coincidence, it is impossible to say. And here it is worthy of observation that the little incision at the meatus is one which has always been looked upon as trivial to the last degree, and one with which the idea of danger is never associated. In fact, so little is it dreaded that division of the meatus is daily required as a preliminary step to urethral exploration.

The period after operative interference at which death occurred is also a matter of interest: it varied in the cases reported from eighteen hours to thirty-seven days. In all of these cases urethral fever had been present to a greater or less degree. The presence of this condition after surgical interference with the urethra is, as is well known, most common, and in fifty-eight cases of urethral operation, viz., division, internal urethrotomy, and external perineal section, Dr. Brinton stated that he had met thirty instances of urethral fever, eleven of which were very severe.

As far as his experience went, it would seem that urethral fever attended with astonishing impartiality upon every form of urethral operation, the severity of the attack being by no means in proportion to the gravity of the operation. As to the localities of stricture, his observations agreed in the main with those of Sir Henry Thompson. Thus, of 132 strictures present in 100 cases, the distribution was as follows:

At meatus	5
At ½ inch from meatus	7
" 1 " " "	4
" 1½ inches " "	4
" 2 " " "	4
" 2½ " " "	6
" 3 " " "	9
" 3½ " " "	4
" 4 " " "	12
" 4½ " " "	6
" 5 " " "	16
" 5½ " " "	24
" 6 " " "	23
" 6½ " " "	5
" 7 " " "	3

In 68 patients the strictures were single; in 29, double; in 3, triple.

The cause of the stricture in the vast majority of instances noted was a gonorrhœa, contracted at various prior periods, varying from one to thirty years, and often terminating in a persistent gleet.

Dr. S. W. Gross said the specimens which have been presented by Dr. Brinton were of extreme interest, as they illustrate the fact that when we have a stricture of the urethra with other diseases of the urinary organs, we are very liable to have unfortunate results follow any operation to relieve the stricture. In hospital practice such as we have it in the Philadelphia Hospital, where the patients come as a last resort, Dr. Gross found all operations upon the urethra to be very fatal, as the specimens exhibited very evidently show: the cause of death in these cases is seen to be various,—surgical kidneys, pyæmia, disease of the prostatic veins, etc. In private practice the results are very different. All of the operations of Dr. Brinton seem to have been of a gentle kind; the dilatation has not been excessive, and there has not been much shock. In the cases operated upon by him (Dr. Gross) he had taken the calibre of the urethra and endeavored to restore it to its normal size. Of twenty-five cases operated upon in the Philadelphia Hospital he had four deaths; in private practice, of seventy-six cases operated upon, no deaths. He had been very careful to bring his patients under the influence of quinine, after the operation to administer hypodermically morphia, and avoided exposing the patient to cold. Dr. Gross had frequently found before the operation that an examination of the urine gave no indication of disease, but immediately after the operation albumen was present. He did not consider the operation dangerous. Death had occurred in two cases in his wards from relieving the bladder of urine by a catheter. Hospital cases are exceptions: no matter what we do, they die; and we should not draw conclusions from them. His experience with the location and number of strictures in the urethra differed somewhat from that given by Sir Henry Thompson: thus, in 200 cases, representing 353 strictures, the seat of the constriction is represented by the following table, the figures denoting inches and parts of inches, commencing at the termination of the urethra at the meatus:

¼	25
¼ to 1¼	55
1¼ to 2¼	25
2¼ to 3¼	24
3¼ to 4¼	14
4¼ to 5¼	45
5¼ to 6¼	118
6¼ to 7¼	46
7½	1

Of the 200 cases, in 101 the stricture was single; in 61, double; in 30, triple; in 5, quadruple; in 2, quintuple; and in 1 there existed eleven strictures.

The exciting causes of the lesion in the 200 cases were gonorrhœa in 160, masturbation in 26, lithiasis in 4, traumatism in 4, phimosis in 2; while it could not be determined in 4.

He thought the operations were not dangerous, provided the rest of the urinary tract was healthy; divulsion not more so than internal urethrotomy: in the latter we can define the stricture and cut it only; with divulsion we do not know what we are doing.

Dr. BRINTON said, in answer to the question of a member as to his method of operating, that he usually prefaced his operation by the administration of quinine, and, if the patient seemed feeble or nervous, by a little stimulus. During the operation, which was performed under ether, every precaution was taken to guard against cold, by wrapping the limbs in blankets, and by covering the chest; afterwards quinine and opium were given internally, or morphia was used hypodermically. The amount of dilatation he employed was moderate, not usually higher than a 22, 23, or 24 Thompson's sound. Frequent instrumentation was most carefully avoided, and any introduction of a catheter or sound was deferred, if possible, until three or four days after the operation, and even then was practised with the utmost caution and gentleness. When the parts were very tender, the patient was permitted to give himself a whiff of ether, so that an instrument could be inserted during the occurrence of that period of early momentary anæsthesia which has been pointed out by Dr. Packard. Dr. Brinton had never lost a case of operation for stricture in private practice.

Dr. GROSS said, with hospital patients we may very frequently have urethral fever and suppression of urine. In private practice this is not the case: he very seldom had in the latter case a chill to follow the operation. Out of 76 cases 9 were so complicated, 2 being the operation of divulsion, and 7 internal urethrotomy; 4 of the last had the operation performed under an anæsthetic. From gradual dilatation he thought there was little danger of fever. He did not believe in gradual dilatation, and thought that stricture could be cured by internal urethrotomy.

Dr. HUNTER asked if any of the cases operated upon by internal urethrotomy had had any return of the stricture, and, if so, how long after the operation. He himself always depended upon gradual dilatation; but in all, if the bougie was not introduced at regular intervals, there was a return of the trouble. The cutting operation leaves a space, which is filled up by cicatricial tissue, which tissue is peculiar in that it contracts: it may be that when formed in the urethra it is of a different nature.

Dr. GROSS, in reply, said it was very difficult to follow cases after operations. He had been able to trace five. In one, three years after the operation there was no return of the lesion; in the others the time since the operation was not so long, being one year to eighteen months, but as yet there had been no return.

Dr. SHAKESPEARE said that more than a year ago he had occasion to study under the microscope some thin sections from two pieces of stricture of the urethra. In the tissue constituting the stricture, besides the usual elements of newly-formed connective or cicatricial tissue, he had found yellow elastic fibres in great abundance. At this same period he had examined cicatrices of incised wounds of the skin, and had failed to demonstrate in them elastic elements.

He thought that possibly the presence of elastic fibres in great numbers in strictures of the urethra might be a very constant occurrence, and might suggest a reason why a cicatrix following division of a urethral stricture has not so strong a tendency to contract as has that succeeding a wound of the skin.

Dr. H. LENOX HODGE said that we must not be led away by the attractiveness of the results of operations for stricture from the pathology of the stricture itself. One of its most marked characteristics is the tendency of the stricture to contract. This shows itself at the beginning, and continues throughout its whole history. Another point of interest in the pathology of stricture is the influence of the curvatures and variations in the diameter of the urethra in determining the locality of the stricture. Again, in all cases of stricture where there is marked contraction of the canal, there is, of necessity, also some pathological condition of the bladder, ureters, and kidneys. The impediment to the flow of urine produces in time chronic cystitis, dilatation of the ureters, and congestions, inflammations, and suppurations in the kidneys. Therefore, in old and bad cases of stricture the constitution is impaired by disease of the whole urinary tract. Any operation that may be done is complicated by this depraved condition of the general health. This, of course, affects persons in both private and hospital practice. Death is, as has been stated, more frequent after the division of stricture in hospital than in private practice. This is due more to the fact that a skilful practitioner is not consulted at an early stage of the disorder, than to any peculiarity in the atmosphere of the hospital ward. Disastrous results are not all confined to hospital practice. He recalled a case in which a very distinguished surgeon had the misfortune to lose in private practice a patient whose stricture he had divided. The patient was in very favorable circumstances, and had what his surgeon considered a very slight stricture. He at first objected to any operation, because the stricture caused him very little trouble. After some hesitation, he consented to have it divided. He died in a few days.

Urethral fever is something more than surgical fever, as his friend Dr. Gross had termed it. Surgical fever occurs even in the most healthy persons on account of some injury or surgical operation. It generally runs a very mild course, and is marked only by a slight rise in the pulse and temperature; whereas urethral fever is usually ushered in by marked chills and runs a rapid and dangerous course. The constitution of the patient is already impaired by disease of the urethra, bladder, and kidneys.

In studying the cause of so sudden a death as one of those related by his friend Dr. Brinton, we must not forget the possibility that it may be due to something else than the ordinary pathology of the disorder. For instance, some patients bear morphia very badly, and at times its exhibition is followed by very alarming symptoms.

As regards the influence exerted upon the pathology of stricture by the treatment of gradual dilatation, his own experience had been very favorable. It is the method of treatment which he preferred. All of the cases which he had been able to follow had been cured. A very marked case occurred to him nineteen or twenty years ago. He had charge of a very bad case of stricture, with numerous urinary fistulæ in the scrotum and perineum. The case was treated by gradual dilatation, and resulted in a perfect cure. He had the opportunity of seeing the patient recently, who has not used a catheter or bougie for many years, can pass a large stream, and has no difficulty whatever.

GLEANINGS FROM EXCHANGES.

DR. HUGHLINGS-JACKSON ON THE CEREBELLUM.—The generally accepted doctrine as to the chief function of the cerebellum is that it co-ordinates the impressions and movements of locomotion. This is equivalent to saying that it represents the impressions and movements of locomotion, or, if we only assert that it is the *chief* centre for locomotor co-ordination, the most special and complex of them. For there is no faculty of co-ordination over and above a representation of impressions and movements themselves. What, then, are the impressions and movements of locomotion which are tacitly asserted to be represented in the cerebellum by those who hold the opinion that it is the co-ordinating centre for locomotion? We will, however, speak only of the movements. In the strictest sense we should probably take in all the movements of the body, or, more correctly speaking, movements of all parts of the body. If this be so, those who say that the cerebellum is the organ for co-ordinating the movements of locomotion say that it represents movements of all parts of the body. Dr. Hughlings-Jackson believes that the cerebrum also represents movements of all parts of the body. There is no reason why the very same muscles should not be represented in different kinds of movement in each centre.

Artificially limiting ourselves to the most conspicuous of the movements of locomotion, we see that they are of the spine, legs, and arms. It is to be borne in mind that the muscles of the spine are necessarily in action in locomotion, and in action first. No one can began to walk until his spine be braced up, and during walking the trunk goes through a very complex motion. Marey says, "These movements are very complex; they are effected at the same time in every direction, and give to the trajectory which a point of the body describes in space, some very complicated sinuosities." And if we say that these movements of the trunk when walking is begun are in one sense produced by the action of the leg, yet without appropriate stiffenings of the spinal muscles the body would fall over in the direction the legs impelled it in. In correspondence we find that the spinal movements are those first to suffer in destroying disease of the cerebellum. The kind of disorderly walking in an early stage of disease of the cerebellum is not paraplegic; it is not the stagger of locomotor ataxy; it is a reel, a drunken-like walk. In an early stage the movements of the legs, tested when the patient is sitting, are powerful. The legs at that stage, it is true, act very erratically when the patient walks, but this is because, the spinal movements being weak, the trunk tends to fall this way and that; the erratic movements of the legs are really "intelligent" attempts to "run after" and prop up the trunk in its various inclinings, which the now weak spinal movements cannot moderate. Similarly in some cases of unsteady movements of the arm, the chief fault is in the muscles which should fix the scapula.

Just as there is no faculty of co-ordination, nor any co-ordination, except in the sense of representation of movements in definite relation one to another with corresponding impressions, so there is no loss nor disorder of co-ordination except in the sense of a loss of function or over-function, more or less, of the representing nervous arrangements. We here speak of loss of function—destruction—of some of them. In an early stage of cerebellar disease there is veritable paralysis or paresis of the spinal movements; the disorderly movements of the legs are secondary effects of that paralysis or paresis. If so, the essential fault is like that in hemiplegia or in any other paralysis: it is a sign of loss of function of some nervous arrangements for some movements. We must not think of hemiplegia simply as a loss of power of muscles, but as a loss of a number of movements of the face, arm, or leg. Similarly, in the cerebellar reel there is loss of a number of movements of the spinal column. If so, we must not class the cerebellar reel with such disorders of co-ordination as chorea; for in the latter there is over-function of the nervous arrangements,—morbidly increased discharges. Looked at superficially, they are different: the reel only exists when the patient is trying to walk; the choreal movements occur at any time. The true analogue of the reel is such a symptom as hemiplegia, not chorea, it being understood that we do not compare with the hemiplegia the erratic movements of the legs, but the loss

of those movements which render these movements necessary,—render necessary wider and more sudden excursions of the legs.

Probably also different spinal movements suffer, or suffer more, in different cases, according to the exact seat of the cerebellar lesion.

If we observe very rapid locomotion, we see how wide the muscular action is: the trunk is bent forward; respiration is suspended for short periods; the arms which are evidently in action in walking—and, as Duchenne and Marey have insisted, not merely in pendulum action—are in running in very strong action; they are in wide action, the activity extending even to the fingers (professional runners carry cork in their hands to prevent their nails hurting their palms); the muscles of the face and jaws are in action; circulation must necessarily be affected. To say, then, that the cerebellum represents the muscles of locomotion is equivalent to saying that it represents movements of all, or nearly all, parts of the body. And, if so, tetanus, however wide the spasm, may plausibly be put down to discharge of some part of this organ, as a discharge of the most special and complex of the nervous arrangements for locomotion. The order of spreading of the spasm of muscles in tetanus follows, if not closely yet generally, the order in which the muscles get into increasing activity in locomotion, from walking to swift running. Thus, then, the cerebellar reel pairs off with cerebral hemiplegia, and tetanus (cerebellar convulsions?) with the unilaterally beginning epileptiform seizure (cerebellar convulsion).

In some cases of hemiplegia there is rigidity of the paralyzed muscles; there is a double condition, a negative and a positive one; there are together paralysis and spasm. The hypothesis suggested is that the paralysis is owing to the cerebral lesion, and the spasm to unantagonized cerebellar influence; there is cerebral paralysis of the same muscles which are subjects of cerebellar spasm.

Again, in cases of cerebellar lesion there ensues after a time rigidity of the parts paralyzed or partially paralyzed by that lesion. For, besides the tetanus-like *paroxysm* of which we have spoken, a permanent rigidity of the muscles of the spine, arms, and legs may come on at a late stage. In a severe case the head is thrown back, the legs are stiffened in extension, and the feet are extended and slightly incurved; the elbows are kept near the side, the forearm is flexed on the upper arm, and the fingers are clenched. —*Medical Times and Gazette.*

THE TREATMENT OF PREGNANCY COMPLICATED WITH CANCEROUS DISEASE OF THE GENITAL CANAL (*The Lancet*, October 19, 1878).—At a recent meeting of the Obstetrical Society of London, Dr. Herman read a paper on the above subject, and narrated two cases which had come under his own care. In one, labor was obstructed by a cancerous tumor of the rectum. The patient was delivered by cephalotripsy, and died from peritonitis. In the other, the cervix uteri was fixed by cancerous disease; abortion was induced at the end of the fifth month. The patient lived seven months afterwards, marked relief to the symptoms having followed the abortion. An analysis of 180 recorded cases, collected from different sources, and classified, was then given. From them he drew the following conclusions. 1. That whatever influence cancer of the uterus may have upon conception is adverse to its occurrence. This was inferred from the small number of cases in which the patient was suffering from cancer at the time conception took place, as compared with the frequency of the disease. 2. That cancer of the uterus tends to produce the intra-uterine death and premature expulsion of the fœtus. This conclusion followed from the large proportion of premature births, and of not only still-born but decomposing children. 3. That the growth of cancer of the uterus is, as a rule, accelerated during pregnancy. This was supported by *a priori* arguments from general pathology, by the analogy of the breast, and by the improvement which often followed the termination of the pregnancy. 4. That with cancerous disease affecting the whole circumference of the os uteri labor may be quick and easy, and the patient may recover well, and live for months afterwards. 5. That when delivery under such conditions is accomplished by natural efforts, expansion of the cervix usually takes place by fissuring. 6. That this fissuring does not usually augment the risk to the mother. 7. That imitation of this natural process, by making incisions, neither increases the danger at the time nor accelerates the progress of the disease subsequently, and that it often greatly facilitates delivery. 8. That the cases in which the cancer forms a tumor of great size or hardness are the ones in which delivery by natural efforts will not take place. 9. That where the above characters are absent, no definite criteria can be drawn from the local conditions by which to foretell the behavior of the os uteri during labor. 10. That where delivery of a living child *per vias naturales* is impossible, such limited experience as we have shows that there is but little difference, as to risk to the mother, between craniotomy and Cæsarean section. 11. That a part of the cervix uteri may with safety be removed either during pregnancy or during labor. These last eight conclusions were supported by the evidence of recorded cases. The author then considered from these data the practice to be followed. He assumed that the life of the mother was the first consideration, and that the production of abortion was justified if maternal life could be saved or prolonged thereby. The following were the rules of practice which he thought indicated. 1. That where it is possible to remove the dis-

ease, either during pregnancy or at the time of labor, it ought to be done. 2. That where this cannot be done, the safety of the mother is best consulted by bringing the pregnancy to an end as soon as possible. 3. That when labor has actually come on, expansion of the os uteri should be aided by making numerous small incisions in its circumference. 4. That dilatation of the cervix uteri being in progress, if uterine action should be deficient, and it should become necessary to accelerate labor, the use of the forceps is, as a rule, better than turning. 5. That when dilatation of the cervix cannot take place, even after incisions have been made, either from rigidity or magnitude of the tumor, Cæsarean section should be performed.

EXPERIMENTAL RESEARCHES ON INFECTION AND ON IMMUNITY FROM VACCINE (*The Lancet*, October 26, 1878).—A memoir of M. Maurice Raynaud, reported in the *Progrès Médical*, contains the following conclusions:

First, as regards the vaccine pustule. The evolution of this vesicle is not requisite to secure immunity. Immunity is effected even when, after sub-epidermic inoculation, the development of the vesicle is prevented by artificial means.

Secondly, in regard to the nervous system, his experiments show that it is quite extraneous or foreign to the completion of the phenomena of vaccine inoculation. For the antecedent section of the nerves distributed to the region inoculated does not interfere with the occurrence of all the symptoms naturally following infection. Nor, indeed, does such section perceptibly modify the march of the vaccine vesicle.

Thirdly, in regard to the blood, he found that the sub-epidermic inoculation of an animal suffering from vaccine never produces vaccinia. This proceeding is not, therefore, susceptible of any practical application. The transfusion even of large quantities of vaccinal blood is not followed by any appreciable effect, since the animal still remains liable to be infected with the vaccine virus. It is possible, however, he thinks, that under certain circumstances the transfusion of a considerable quantity of vaccinal blood into an animal may render it incapable of contracting vaccinia without inducing any other change in it. But, even then, the immunity thus acquired could not be propagated in the same way to a third individual. It hence appears to be highly improbable that the blood is the means by which the vaccine virus generalizes itself through the economy at large.

Fourthly, in regard to the lymphatics, he finds that the sub-epidermic inoculation of lymph taken from a vaccinated region, or taken beyond the nearest ganglion, gives the same negative results as the sub-epidermic inoculation of vaccinal blood. On the other hand, by injecting some grammes of this lymph into the blood of a horse, M. Raynaud has succeeded in inducing the appearance of "horse-pox." This lymph, then, appears to possess some virulence if employed in somewhat strong doses.

Fifthly, in regard to the lymphatic ganglia, he finds that after normal vaccination the ganglion nearest to the spot vaccinated is invariably congested, although hitherto this fact has been overlooked or misunderstood. The congestion quite justifies the application of the term vaccinal bubo applied to it. The bubo is indolent, and presents no inflammatory reaction. Nevertheless, inoculation with the juice of this ganglion, whenever it may be performed, does not produce cow-pox. It is possible, then, to recognize traces of virulence in the lymphatic system between the place of inoculation and the nearest ganglion, but beyond this point no traces are discoverable. This circumstance seems to suggest that an elaborating function may be attributed to the lymphatic ganglia, expressing itself in the disappearance of virulence and the supervention of immunity, two facts which are simultaneous and correlative.

MISCELLANY.

ON Saturday the 9th of November a committee appointed by the Maryland Academy of Sciences, and approved by the Academy of Medicine and the Baltimore Medical Association, consisting of Drs. J. R. Uhler, C. C. Bombaugh, and C. L. Oudesluys, waited on President Hayes with the following memorial:

"*To the President:*

"The undersigned, a committee appointed by the Maryland Academy of Sciences, most respectfully request you to transmit to Congress a message asking an appropriation and authority to appoint a permanent scientific and medical commission, to study and report upon the nature, causes, treatment, and prevention of yellow fever and allied epidemic diseases; said commission to consist of twenty or more members, chosen from the ablest chemists, physicists, microscopists, biologists, naturalists, and physicians in the country, with power to select, from their own number and others, workers, in order that the disease may be systematically examined from different points of view, both by acclimated members on the spot and others in the various laboratories of our country.

"J. R. UHLER, M.D.,
CHARLES L. OUDESLUYS,
REV. JOHN M. HOLMES,
GEORGE W. DAVIDSON,
P. G. SAUERWEIN,
C. C. BOMBAUGH, M.D."

During the conversation that ensued, the following important points were made: 1. That the investigation should be commenced

at once in the interval before another epidemic, in order that the healthy conditions of the air, water, food, plant, and animal life may be accurately ascertained. 2. That the investigations should be made by a large number of competent persons, the acclimated ones working on the spot, the others in the various laboratories of our country. 3. It is particularly important that said work should be systematic, in contradistinction to the random efforts hitherto employed. 4. A number of names of men possessing a national reputation from the various large universities of the country, consisting of a naturalist, a cryptogamic botanist, biologists, chemists, physicists, physiologists, microscopists, and experimental physicians, were suggested. Both the memorial and suggestions were favorably received, and the President thought it would be well to give the matter wide publicity, in order that the profession and others might bring it to the attention of Congressmen and thus insure the passage of the bill.

FILTERING WATER.—Dr. Nolter, Assistant Professor of Hygiene at Netley Army School, has arrived at the following results as the conclusion of an elaborate series of experiments:

1. Filtration through sand is simply mechanical for the most part, and not to be depended on as a purifier.

2. Water may be purified by animal charcoal to a large extent; that its action is extremely rapid on decomposed organic matter; that fresh organic matter passes through unchanged; and that water should on no account be stored after filtration, as this matter subsequently decomposes, giving rise to low organisms. It is advisable not to leave the water in contact with the animal charcoal for a lengthened period, as it again takes up impurities from the medium.

3. That spongy iron is undoubtedly the *best* filtering material. Its action is not so rapid as charcoal, but there is no danger in prolonging the contact with the water. As far as my experiments go, it is the only *safe* filtering medium we have at present. It appears to act on all organic matter, whether fresh or decomposed, whereas charcoal acts more as a dialyzer when colloidal substances are fresh and in a state of extreme dilution, and are certain to decompose after filtration.

One feature of filtering through charcoal must not be lost sight of,—that charcoal becomes exhausted of its oxygen, and that foul gases held in solution by the water may replace it. Its action is limited, and it requires constant attention.

NOTES AND QUERIES.

43 WEST 54TH STREET, NEW YORK, Nov. 25, 1878.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

SIR,—I think the editorial in the last number of the *Medical Times* is unjust to me in several particulars. As the matter between Drs. Grissom and Gray and myself is now before a court of law, I have no intention of entering into any defence in this place, or of doing more than expressing my regret that you should have been led into such a one-sided expression of opinion.

As you have not, apparently, seen my replies to Dr. Grissom, I send you copies by this mail, and I think you will find by perusing them that I had ample ground for my strictures on that individual and my action against Dr. Gray.

I am, very respectfully, your obt. servt.,

WILLIAM A. HAMMOND.

[Before writing the editorial alluded to, we read carefully the replies of Dr. Hammond, and the more we read the more we wondered that a person possessed of any sense or gentlemanly instincts should write such "stuff." If Dr. Hammond be innocent, he has suffered more injustice at the hand of Dr. Wm. A. Hammond than from any other living man, Drs. Gray and Grissom not excepted.—ED. *P. M. T.*]

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

In your notice of the controversy between Drs. Grissom and Hammond, in the number for November 9, is one statement not exactly correct. After Dr. Grissom's paper was read to the Association of Superintendents, a resolution was offered protesting against the character of the paper and invoking upon it the condemnation of the Association. Three members supported it, for the reason, as they said, that that was neither the time nor the place for assailing the professional or moral character of any one. It is not to be inferred, however, that the rejection of the resolution was equivalent to the endorsement of the paper by the Association. Several of the members who voted in the negative expressed the prevailing sentiment in saying, as the ground of their action, that they did not consider the Association responsible for the sayings of its individual members. To pass a vote of censure of Dr. Grissom's paper, whatever they might think of it, would be to abandon a principle which had always been maintained by the Association.

A MEMBER OF THE ASSOCIATION.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

MR. EDITOR,—I am well aware that you cannot open your columns to the discussion of homœopathy, but, as you have admitted Dr. Neidhard's letter, will you allow me to offer a brief comment on a passage in it, and a suggestion that, to my mind, is conclusive of the whole subject?

Dr. N. says, "Let it, once for all, be understood that the homœopathic practice does not merely consist in giving infinitesimal doses,"—if so, the name is a marvel of absurd inaccuracy),—"but in the correct application of the specific remedy, according to the principle of the homœopathic law." In other words, let it be understood that homœopathic practice is the practice of homœopathy. This will probably be admitted by every one; but the doctor goes on to say, "This similarity will in some cases be more analogous to the symptoms, in others to the pathological state of the case under consideration, as far as this can correctly be ascertained." Would it not be deducible from this that the symptoms do not always tell a true tale as to the pathological state, and hence that the treatment of symptoms may be a mistake, and hence, further, that the study of scientific pathology, the basis of all sound practice, would be better than that of mere symptoms and doses?

Now for my suggestion. It is simply that any one who can, out of the vast body of observers interested, should report a case in which belladonna has produced any but the most superficial and non-essential symptoms of scarlatina; or one in which opium has produced diarrhœa; or one in which quinine, in large or small doses, has produced the phenomena of intermittent fever; or one in which mercury has given rise to those of constitutional syphilis, or in which iodide of potassium has had this effect; or in which bromide of potassium has induced epileptiform seizures. Or, more generally, any disease or epidemic in which, subjected to fair tests, homœopathic practice has been shown to be more successful than that of regular physicians.

Homœopaths will be delighted, I am sure, to produce an ample array of such cases, fully attested,—if they exist; and, on the other hand, it is certain that physicians of the old school will be unable to suppress them,—on the same condition.

If they do not exist, it seems to me that we can scarcely be accused of prejudice if we decline to award homœopathy any scientific status. Now that homœopaths are seeking to break down the existing barriers between them and the regular profession, it is time for them to show what claims, if any, they have upon the consideration of those whom they have so long and so systematically accused of prejudice, old-fogyism, and I know not what besides.

Yours, respectfully,

FAIR PLAY.

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The advantages claimed for this form of Iron are due to the absence of free acid, which is dependent upon the perfect dialysation of the solution. The samples of German, French, and American Liquor Ferri Oxidi Dialys., which we have examined, give acid reaction to test paper. If the dialysation is continued sufficiently long, it should be tasteless and neutral.

Our Dialysed Iron is not a saline compound, and is easily distinguished from Salts of Iron by not giving rise to a blood-red color on the addition of an Alkaline Sulpho-Cyanide, or a blue precipitate with Ferro-Cyanide of Potassium. It does not become cloudy when boiled. When agitated with one part of Alcohol and two parts of Ether (fortior), the Ether layer is not made yellow.

Physicians and Apothecaries will appreciate how important is the fact that, as an antidote for poisoning by Arsenic, Dialysed Iron is quite as efficient as the Hydrated Sesquioxide (hitherto the best remedy known in such cases), and has the great advantage of being always ready for immediate use. It will now doubtless be found in every drug store to supply such an emergency.

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As the taste of this article is not disagreeable, we have prepared it in the form of Compressed Tablets, thus giving the patient the full benefit of its action, undiluted with Sugar, Gum, or other vehicles, which would not only prevent its effects, but which sometimes themselves offend the stomach.

The Lozenges usually contain about twenty-five (25) grains of gum and sugar, with two grains of the Chlorate of Potash, while each of these Pills contains simply five grains of the Chlorate, all of which, dissolved in the saliva, acts on the affected mucous membranes.

If allowed to dissolve in the mouth, the topical effect is much more efficient than a saturated solution, as while the solution is but temporary, the tablet really acts as a continuous gargle.

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DIRECTIONS.—Adults should take one every hour or two until relieved, allowing it to dissolve slowly in the mouth. Children, half of one as often.

For Offensive Breath, no remedy will give more certain relief; use one two or three times a day.

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To the Medical Profession.

LACTOPEPTINE,

The most important remedial agent ever presented to the Profession for Indigestion, Dyspepsia, Vomiting in Pregnancy, Cholera Infantum, Constipation, and all Diseases arising from imperfect nutrition, containing the five active agents of digestion, viz.: Pepsin, Pancreatine, Diastase, or Veg. Ptyalin, Lactic and Hydrochloric Acids, in combination with Sugar of Milk.

FORMULA OF LACTOPEPTINE.

Sugar of Milk	40 ounces.	Veg. Ptyalin or Diastase .	4 drachms.
Pepsin	8 "	Lactic Acid	5 fluid drachms.
Pancreatine	6 "	Hydrochloric Acid . .	5 "

LACTOPEPTINE owes its great success solely to the Medical Profession, and is sold almost entirely by Physicians' Prescriptions. Its almost universal adoption by the profession is the strongest guarantee we can give that its therapeutic value has been most thoroughly established.

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A. Van Deveer, M.D.,
Albany, N. Y., June 8, 1878.
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"I have given LACTOPEPTINE a good, thorough trial, and have been greatly pleased with the excellent results that have followed its administration."

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"I have found great satisfaction in the use of LACTOPEPTINE, and have ordered it frequently in cases of Dyspepsia, especially where there is want of tone and defective secretion."

James Aitken Meigs, M.D.,
Philadelphia, Pa., June 20, 1878.
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W. W. Dawson, M.D.,
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PANCREATIC EMULSION will always take precedence of Cod Liver Oil by reason of its introducing the STABLE SOLID FATS INTO THE SYSTEM instead of the evanescent fluid fats or oils.

Neither Cod Liver Oil nor *Emulsions of Cod Liver Oil* can supply the kind of fat necessary for sound and vigorous human life. In addition to this, all the Oily Emulsions are liable to rancidity, and most of them are highly objectionable in consequence of the *Saponification* and *ultimate putrefaction* produced by the chemical agents used instead of Pancreatic Juice.

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PANCREATINE effects the digestion and assimilation of Cod Liver Oil and Fat, as well as food generally. This palatable and popular remedy is therefore invaluable to *patients who are unable to digest Cod Liver Oil*, and who are thus deprived of its nourishing and invigorating properties.

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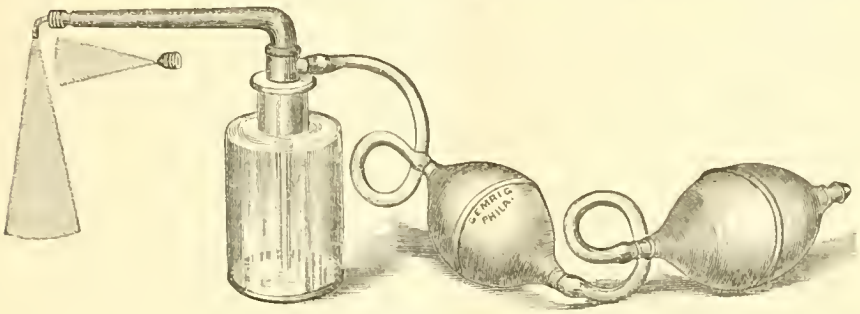

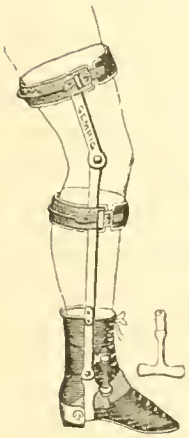

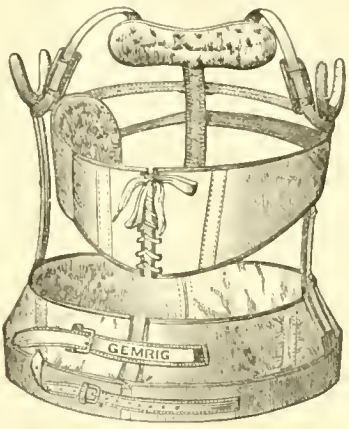

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MALTINE.

(EXTRACT OF MALTED BARLEY, WHEAT, AND OATS.)

THIS PREPARATION
Contains from three to five times the Medicinal and Nutritive elements found in Extract of Malt.

MALTINE is a highly concentrated extract of malted *Barley, Wheat,* and *Oats,* containing, undiminished and unimpaired, all the medicinal and nutritious principles found in these cereals. By the most carefully conducted scientific process we are enabled to offer to the medical profession a perfect article, possessing from *three* to *five* times the therapeutic and nutritive merit of any foreign or domestic Extract of Malt.

IN SUPPORT OF OUR CLAIMS WE INVITE THE ATTENTION OF THE PROFESSION TO THE FOLLOWING POINTS, VIZ.:

FIRST: In the manufacture of **MALTINE** the evaporation necessary to reduce it to its great density is conducted in vacuo, at a temperature ranging from 100° to 120° Fahr.; while most manufacturers of Extract of Malt resort to "open pan" or low-pressure steam boiling, by neither of which processes can the extract be so produced as to preserve the Diastase, Phosphates, and Albuminoids on which its remedial value so greatly depends, and the product is either of a dark color or of low specific gravity, possessing little virtue aside from the saccharine matter which it contains.*

SECOND: *Carbon, Hydrogen, Nitrogen, Phosphorus, Sulphur, Iron, Magnesium,* and *Potassium* are essential elements in the food of man, and it is only in **MALTINE,** containing the combined properties of malted *Barley, Wheat,* and *Oats,* that all these principles can be found in the proper proportions. Extract of Malt made from *Barley alone* is wanting in some of the most important of these elements.

THIRD: *Gluten* is the most nutritious principle found in the cereals, and is the only vegetable substance which will, alone, support life for any great length of time. It is composed of three distinct nitrogenous principles, together with fatty and inorganic matters, and is analogous to animal fibrin. **MALTINE** contains twenty times the quantity of *Gluten* found in any Extract of Malt.

FOURTH: LIEBIG says,—"Wheat and Oats stand first among our list of cereals in combining all the elements in proportions necessary to support animal life. They are especially rich in muscular- and fat-producing elements." The only reason we use Malted Barley in the manufacture of **MALTINE** is that it contains larger proportions of mineral matters (bone producers) and Diastase. It is deficient in all other essential elements.

We believe that any practitioner will readily recognize the superiority of MALTINE, and would request a trial and comparison of merits with any article offered for similar uses.

* As a sure test for Diastase and the Albuminoids, a small quantity should be put in a test tube or small vial, largely diluted with water, and heated to the boiling-point, when the Albumen, if present, will coagulate, and appear in little flocculent particles throughout the liquid. If the extract remains clear, it is proof that it has already been coagulated by excessive heat, and removed by filtration during the process of manufacturing. Any heat which will coagulate Albumen will inevitably destroy the digestive power of Diastase.

The Nitrogenous constituents of *MALTINE* have a composition identical with that of the chief constituents of the Blood, and therefore contain nearly every element requisite for the reproduction of the human body.

MALTINE AND ITS COMPOUNDS

can undoubtedly be used with greater success than any other remedy now known, in cases of General and Nervous Debility, Indigestion, Imperfect Nutrition, and Deficient Lactation; Pulmonary Affections, such as Phthisis, Coughs, Colds, Hoarseness, Irritation of the Mucous Membrane and Difficult Expectoration; Cholera Infantum, and wasting diseases of children and adults; Convalescence from Fevers, and whenever it is necessary to increase the vital forces and build up the system.

WE MANUFACTURE THE FOLLOWING PREPARATIONS, THE FORMULAS AND DOSES OF WHICH ARE GIVEN IN OUR DOSE BOOKS AND ON THE LABEL ATTACHED TO EACH BOTTLE:

***MALTINE*, WITH HOPS.**

***MALTINE*, FERRATED:**
This combination is specially indicated in Anæmia and Chlorosis, and in all cases of defective nutrition where iron is deficient in the system.

***MALTINE*, WITH PHOSPHATES IRON AND QUINIA:**
A powerful general and nutritive tonic.

***MALTINE*, WITH PHOS. IRON, QUINIA, AND STRYCHNIA:**
A powerful nutritive, general, and nervous tonic.

***MALTINE*, WITH PEPSIN AND PANCREATINE:**
One of the most effective combinations in Dyspepsia, Cholera Infantum, and all diseases resulting from imperfect nutrition. It contains three of the all-important digestive agents, Diastase being one of the constituents of the ***MALTINE***. We believe there are few cases of Dyspepsia which will not readily yield to the medicinal properties of the above combination, while the system is invigorated by its nutritive qualities.

***MALTINE*, WITH BEEF AND IRON:**
One of the most valuable combinations in cases of General Debility, where there is deficient nutrition and a deficiency of iron in the system.

***MALTINE*, WITH ALTERATIVES:**
In this preparation ***MALTINE*** is combined with the most valuable alteratives known, such as Iodides, Bromides, and Chlorides, and will fully meet the requirements of the practitioners in Syphilis, Scrofula, and all depraved conditions of the blood.

MALTINE WINE.
This preparation contains all the medicinal and nutritive constituents of ***MALTINE***, less 60 per cent of the transformed starch or glucose, which renders the preparation lighter and more acceptable to some stomachs, and is recommended only in such cases.

***MALTINE WINE*, WITH PEPSIN AND PANCREATINE:**
(Each fluidounce of MALTINE WINE contains 15 grains pure PEPSIN and 15 grains pure PANCREATINE.)
We can recommend this preparation to the Medical Profession as being the most important remedy ever brought to their notice in all cases of Dyspepsia and Imperfect Nutrition, when the system needs invigorating and replenishing. It will be found, we believe, a perfect remedy in Vomiting in Pregnancy, Cholera Infantum, and wasting diseases of children, and in Constipation and Chronic Diarrhœa resulting from mal-nutrition. It will agree with the most irritable stomach

MALTO-YERBINE.
(Each pint of the above preparation contains 13 ounces MALTINE, 2 ounces CARRAGEEN, and 1 ounce YERBINE.)
With the nutritive, emollient, and demulcent properties of ***MALTINE*** and ***CARRAGEEN***, and the expectorant qualities of ***YERBINE*** (active principle of Yerba Santa), we offer this preparation to the Profession with the fullest confidence that it is the most perfect remedy yet produced in Chronic Pulmonary Affections, Irritation of the Mucous Membrane, Difficult Expectoration, Bronchitis, and ordinary Coughs and Colds.
The Dose of all preparations of ***MALTINE*** and compounds is from a dessert- to a tablespoonful.

We also manufacture a perfectly prepared EXTRACT OF MALT, from *Barley only*.

MALTINE preparations are sold at the same prices as EXTRACT OF MALT and its combinations, and are put up in half-pint, pint, and five-pint amber bottles; each bottle enclosed in a folding paper box.

REED & CARNRICK,
Manufacturing Pharmacists,
196 and 198 FULTON STREET, NEW YORK.

TROMMER'S EXTRACT OF MALT.

The rapidly increasing demand for our IMPROVED EXTRACT OF MALT, during the four years that it has been manufactured and offered to the medical profession in America, justifies the belief that in its production here we are meeting a generally felt want.

Long experience in manufacturing Malt Extract has enabled us to completely overcome the many difficulties attending its manufacture in large quantity; and we positively assure the profession that our Extract of Malt is not only perfectly pure and reliable, but that it will keep for years, in any climate, without fermenting or moulding, and that its flavor actually improves by age. Our Extract is guaranteed to equal in every respect the best German make, while, by avoiding the expenses of importation, it is afforded at less than half the price of the foreign article.

The Malt from which it is made is obtained by carefully malting the very best quality of selected Toronto (Canada) Barley. The Extract is prepared by an *improved process*, which prevents injury to its properties or flavor by excess of heat. **It represents the soluble constituents of Malt and Hops,** viz., MALT SUGAR, DEXTRINE, DIASTASE, RESIN and BITTER OF HOPS, PHOSPHATES OF LIME and MAGNESIA, and ALKALINE SALTS.

Attention is invited to the following analysis of this Extract, as given by S. H. Douglas, Professor of Chemistry, University of Michigan, Ann Arbor.

TROMMER EXTRACT OF MALT CO.—I enclose herewith my analysis of your Extract of Malt:

Malt Sugar, 46.1; Dextrine, Hop-bitter, Extractive Matter, 23.6; Albuminous Matter (Diastase), 2.469; Ash—Phosphates, 1.712; Alkalies, .377; Water, 25.7; Total, 99.958.

In comparing the above analysis with that of the Extract of Malt of the German Pharmacopœia, as given by Hager, that has been so generally received by the profession, I find it to substantially agree with that article.

Yours truly, SILAS H. DOUGLAS,
Professor of Analytical and Applied Chemistry.

This invaluable preparation is highly recommended by the medical profession as a most effective therapeutic agent for the restoration of delicate and exhausted constitutions. It is very nutritious, being rich in both muscle- and fat-producing materials.

The very large proportion of *Diastase* renders it most effective in those forms of disease originating in *imperfect digestion of the starchy elements* of food.

A single dose of the Improved Trommer's Extract of Malt contains a larger quantity of the active properties of malt than a pint of the best ale or porter; and, not having undergone fermentation, is absolutely free from alcohol and carbonic acid.

The dose for adults is from a dessertspoonful to a tablespoonful three times daily. It is best taken after meals, pure or mixed with a glass of milk, or in water, wine, or any kind of spirituous liquor. Each bottle contains 1½ lbs. of the Extract.

Our preparations of Malt are for sale by druggists generally throughout the United States and Canada, at the following prices.

EXTRACT OF MALT,	*With Hops (Plain)*	$1.00
" " "	*Phosphate of Iron (Ferrated)*	1.00
" " "	*Cod Liver Oil*	1.00
" " "	*Cod Liver Oil and Iodide of Iron*	1.00
" " "	*Cod Liver Oil and Phosphorus*	1.00
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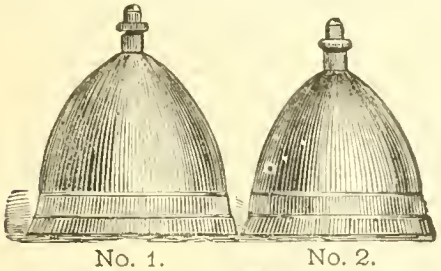

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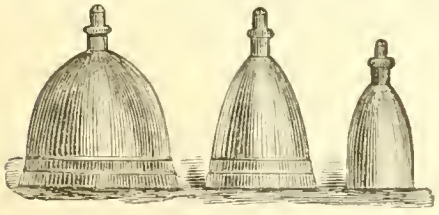

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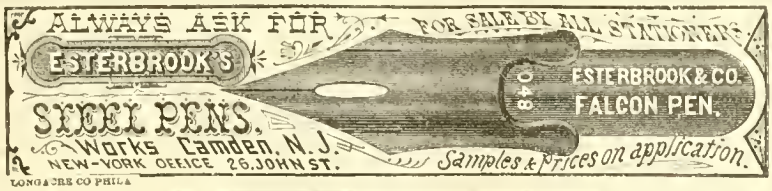

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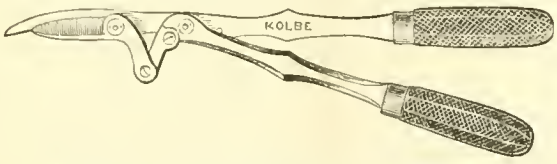

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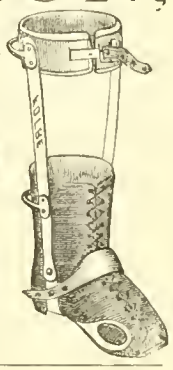

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